	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE COMPL	
711.12 112.11	o. condenion	155695	A. BUILDING B. WING			02/11/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/ 1 // 2	
NAME OF F	PROVIDER OR SUPPLIER	t		l	FRANKLIN ST		
RIVERSI	DE VILLAGE			l	RT, IN46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
F0000	This visit was for	r a Recertification and	F00	00	The creation and submission	1	
	State Licensure S	Survey.			of this plan of correction doe		
					not constitute an admission		
	Survey dates: February 7-11, 2011				this provider of any conclusi set forth in the statement of	on	
		•			deficiencies, or of any violati	on	
	Facility number:	003075			of regulation.This provider		
	Provider number				respectfully requests that the	•	
	AIM number: 20	00364160			2567 plan of correction be considered the letter of		
					considered the letter of credible allegation and reque	est	
	Survey team:				a post certification review on		
	Honey Kuhn, RN	N, TC			or after 03/13/2011.		
	Mavis Stob, RN Carol Miller, RN						
	Census bed type:	:					
	SNF/NF: 86						
	Total: 86						
	Census payor typ	1 0.					
	Medicare: 11	<i>5</i> C.					
	Medicaid: 70						
	Other: 5						
	Total: 86						
	Sample: 18						
	Supplemental sar	mple: 2					
	These deficiencie	es also reflect state					
	findings in accor	dance with 410 IAC 16.2.					
		/18/11 by Suzanne					
	Williams, RN						
LABORATOR	L RY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WWYP11 Facility ID:

003075

If continuation sheet

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155695		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPL 02/11/2	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0157 SS=D	facility failed to ophysician and the Attorney in regard of influenza vacce failed to consult regard to a medication for 3 medications for 3 This deficiency a reviewed for physample of 18. Findings include 1. The clinical was reviewed on indicated an admidiagnoses which limited to demendisease. A significant chard data set) assessmindicated the resimpairment and be consulted to the influenza vacce was no document.	e resident's Power of ed to a resident's refusal sine (Resident #42), with the physician in eation order (Resident o notify the physician in ent not receiving ordered 3 days (Resident #87). Iffected 3 of 18 residents sician's orders in a	F01	57	F 0157What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provider to promptly inform the resident, consult with the resident's physician, and notify the resident's legal representative interested family member when there is a significant change in the resident's physical, mentar psychosocial status and/or the need to alter treatment significantly. Resident # 42 flu vaccine was given on 11/09/2010. Resident # 22 physician was contacted and informed of medication discrepancy. Resident # 87 has been discharged from the facility. The above mentioned residents experienced no negative outcome as a result this finding. How will you idented the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this finding. Newly admitted or readmit residents' medical recombination. Will be audited by the Nurse Management Team using the Admission/Readmission Review Worksheet. This ongoing audit will ensure physician and faminotification for change in condition and alteration/refusal	or en n l, or e sord IDT ew t	03/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED
ANDILAN	OF CORRECTION	155695	A. BUI	LDING		02/11/2011
		155095	B. WIN			02/11/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
DIVEDGI	DE VILLAGE				/ FRANKLIN ST .RT, IN46516	
					+	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG		<u> </u>	+	IAU	treatment as well as immuniza	
	in regard to the resident's refusal of the vaccine. An authorization form giving				administration. What measure	
		• •			will be put into place or what	
	-	e facility to administer			systemic changes you will	
		been signed by the Power			make to ensure that the	
	of Attorney on 9/	/18/10.			deficient practice does not	
					recur?Licensed Nurses will be	
	When interviewe	ed on 2/9/11 at 8:42			in-serviced on 3/10/2011. This in-service will include review o	I
	A.M., the DNS, v	who had only been			the facility policy titled,"Reside	
	employed by the	facility for 1 week,			Change of Condition" as well a	
	indicated the phy	sician and the family			the policy titled, "Nursing	
	should have been	notified.			Admission/Return Admission	
					Procedure". This in-service will include review of notification a	
	2. The clinical re	ecord of Resident #22			documentation guidelines for	iiu
		2/10/11 at 2:15 P.M.,			refusal of medications, treatme	ent,
		admission date of			and clarification of re-admission	on
		gnoses which included,			orders. The nurse managers v	vill
		ted to, dementia and			review the 24 Hour Condition	
		cancer with mastectomy.			Report daily to identify any significant change in condition	
	liistory or oreast	cancer with mastectomy.			refusal of medications, refusal	I
	A physician's ard	ler, dated 1/10/11,			treatments, etc The	
					admission/re-admission physic	I
		in D 50,000 U (units) Q			orders will be reviewed by two	
	` • ′ `	x) po (oral) x 8 wks"			licensed nurses to ensure accurate transcription of all	
		nuary 2011 MAR			orders.How will the corrective	e
	`	inistration record)			action(s) be monitored to	
		dent received the vitamin			ensure the deficient practice	
		n $1/13/11$, the resident			will not recur, i.e. what qualit	-
		the hospital and returned			assurance program will be p	ut
		1/18/11. There was no			into place?An, "Admission/Readmission	
		min D 50,000 units on			Procedure" CQI tool will be	
	the discharge me	dication orders and there			utilized weekly x4 and monthly	,
	was no document	tation to indicate the			thereafter to monitor ongoing	
	physician had be	en consulted in regard to			compliance with this finding. Ir	
	the vitamin D.				addition the facility will utilize t	
					CQI tool titled, "24 Hour Condi	uon

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011	
	PROVIDER OR SUPPLIEF	!	STREET 1400 V	ADDRESS, CITY, STATE, ZIP CODE V FRANKLIN ST ART, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
	hospital again or the facility on 2/2 no order in regar units on the hosp. There was no do physician had be the order for the units. During interview A.M., the DNS if find documentation the physician in the physician in the second property of the second property of the second property of the physician in the physician in the second property of the second property	s transferred to the in 1/31/11 and returned to 2/11. Again, there was id to the vitamin D 50,000 bital discharge orders. Cumentation the sen consulted in regard to weekly vitamin D 50,000 or on 2/11/11 at 9:30 indicated she could not ion of consulting with regard to continuation of 0,000 units every week for		Report" weekly x4 weeks at then monthly thereafter. The "Refusal of Medication and Treatment" CQI tool will be utilized weekly x4 then monthereafter. Findings will be submitted to the CQI Commfor review and follow up. The and/or designee will be responsible for the program compliance. Compliance Da 03/13/2011	thly nittee e DNS	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155695	B. WIN			02/11/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				V FRANKLIN ST	
RIVERSI	DE VILLAGE				ART, IN46516	
			_			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
F0157		inical record of Resident	F01	57	F 0157What corrective	03/13/2011
SS=D	#87 was reviewe	d on 2/9/11 at 2:15 p.m.,			action(s) will be accomplished	ea
	and indicated the	resident had diagnoses			for those residents found to have been affected by the	
	including, but no	t limited to,			deficient practice?It is the	
	hypothyroidism a				practice of this provider to	
	intertrochanteric	•			promptly inform the resident,	
	intertrochameric	nacture.			consult with the resident's	
	The District	0.1 1.4. 1.10/20/10			physician, and notify the	
	· ·	Order dated 10/30/10,			resident's legal representative	
		dent had an order for			interested family member whe	
	levothyroxine 10	0 micrograms (used for			there is a significant change in	
	hypothyroidism)	administer one tablet			the resident's physical, mental psychosocial status and/or the	·
	once a day.				need to alter treatment	;
	The Physician's (Order Sheet dated			significantly.Resident # 42	
	The state of the s	indicated the resident			flu vaccine was given on	
	had an order since				11/09/2010.Resident # 22	
					physician was contacted and	
		e tablet once a day and an			informed of medication	
		7/10, for the medication			discrepancy.Resident # 87 has	s
		igrams (used as an			been discharged from the	
	appetite stimulan	t) administer one tablet			facility. The above mentioned residents experienced no	
	once a day at bed	ltime.			negative outcome as a result of	of
					this finding. How will you iden	
	The Medication	Administration Record			other residents having the	
	 dated 1/2011 inc	licated the 5 a.m. dose of			potential to be affected the	
		0 micrograms, the			same deficient practice and	
	_	•			what corrective action will be	e
		igrams one tablet at			taken?All residents have the	
	·	multivitamin one tablet			potential to be affected by this	
	,	circled as not given from			finding. Newly admitted or	
	1/1/11 through 1/	/3/11.			readmit residents' medical rec will be audited by the Nurse	ora
					Management Team using the	TOI
	The Nurses Note	s dated 1/1 through			Admission/Readmission Revie	
		the Physician had not			Worksheet. This ongoing audi	I
	·	the medication refusals.			will ensure physician and fami	
	occir notified of t	medication foldsuis.			notification for change in	
					condition and alteration/refusa	l of
					1	

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUL:			(2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155695	B. WIN			02/11/20	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			FRANKLIN ST		
DIVEDS	IDE VILLAGE			1	RT, IN46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		45 p.m., the ADNS			treatment as well as immuniza		
	(Assistant Director Nursing Services) was				administration. What measure		
	interviewed in re	egard to the Physician's			will be put into place or what		
		ne resident's refusals of			systemic changes you will make to ensure that the		
	medication for three consecutive days.				deficient practice does not		
	The ADNS indicated the Physician should				recur?Licensed Nurses will be	.	
		-			in-serviced on 3/10/2011. This		
		d after the third day of			in-service will include review o	f	
	consecutive med	lication refusal.			the facility policy titled,"Reside	nt	
					Change of Condition" as well a	as	
	The policy for R	esident Refusal of			the policy titled, "Nursing		
	Medication, dated as revised on 3/10, and				Admission/Return Admission	.	
	reviewed on 2/10/11 at 1:45 p.m.,				Procedure". This in-service will include review of notification a		
	indicated "Policy				documentation guidelines for	iiu	
		f this facility to allow the			refusal of medications, treatme	ent.	
		t to refuse services			and clarification of re-admission		
	1				orders. The nurse managers v	vill	
	_	ng medications This			review the 24 Hour Condition		
	_	cognizes that it is the			Report daily to identify any		
		bility as a healthcare			significant change in condition		
	provider to ensu	re that the residents			refusal of medications, refusal	of	
	entrusted to our	care receive care and			treatments, etc The admission/re-admission physic	rian	
	services to attain	and maintain the highest			orders will be reviewed by two		
		ing physically, mentally			licensed nurses to ensure		
	and psychosocia				accurate transcription of all		
	1	refuses administration of a			orders.How will the corrective	e	
					action(s) be monitored to		
		three (3) consecutive			ensure the deficient practice		
	1	ianwill be contacted			will not recur, i.e. what qualit	- 1	
	and made aware	of the refusals."			assurance program will be p	ut	
					into place?An,		
	3.1-5(a)(3)				"Admission/Readmission Procedure" CQI tool will be		
					utilized weekly x4 and monthly	,	
					thereafter to monitor ongoing		
					compliance with this finding. Ir	1	
					addition the facility will utilize t		
					CQI tool titled, "24 Hour Condi	ition	

AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY	
II A. BUILDING		A. BUILDING		COMPLETED		
		155695	B. WING		02/11/2011	
NAME OF DD	DOMINED ON CLINDLIED		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER	•	1400 W	/ FRANKLIN ST		
	DE VILLAGE			RT, IN46516		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Report" weekly x4 weeks and then monthly thereafter. The "Refusal of Medication and Treatment" CQI tool will be utilized weekly x4 then monthly thereafter. Findings will be submitted to the CQI Committed for review and follow up. The E and/or designee will be responsible for the program compliance. Compliance Date 03/13/2011	ly ee DNS	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE			COMPLETED
		155695	B. WIN			02/11/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				/ FRANKLIN ST	
RIVERSI	DE VILLAGE			l	RT, IN46516	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
F0164		ation and interview, the	F01	64	F 0164	03/13/2011
	facility failed to	maintain privacy during			What corrective action(s) wil	·
	treatments in reg	ard to closing the privacy			be accomplished for those	
		ing the door (Resident			residents found to have beer	1
		4, Resident #45, and			affected by the deficient practice?	
	· ·	This deficiency affected 3			It is the practice of this provide	er
	l ′	nple of 18 and 1 resident			that each resident has the righ	
		•			personal privacy and	
	in the supplemen	ital sample of 2.			confidentiality in regards to	
					personal care and medical	
	Findings include	:			treatment.	
	1. On 2/8/11 at 10:50 A.M., nurse #20 was observed giving a bolus enteral				Resident # 80, resident # 74,	
					resident # 67, and resident # 4	
					experienced no negative outcomes as a result of this finding. Any	one
		a G (gastrostomy) tube.			identified staff members will be	<u> </u>
	-	s in the bed adjacent to			thoroughly in-serviced and	
		·			re-educated on resident dignit	y.
		the only resident in the			How will you identify other	
		. Nurse #20 did not			residents having the potentia	al
	close the room do	oor or pull the privacy			to be affected the same	
	curtains around t	he bed. During the			deficient practice and what	
	process the reside	ent's abdomen was			corrective action will be take	
	exposed.				All residents have the potentia	
	1				be affected by this finding and be identified through routine/	WIII
	2 On 2/11/11 s	at 9:50 A.M., CNA			random nurse rounds. Any	
		g assistant) #21 entered			concerns identified will be	
	`				corrected immediately.	
		lent #74 to check the			What measures will be put in	to
		ntinence. The resident			place or what systemic	
		ljacent to the door. The			changes you will make to	
	other bed was oc	cupied and the curtain			ensure that the deficient	
	between the beds	s was slightly pulled.			practice does not recur?	
					An all staff in-service will be he	
	The CNA did no	t close the room door or			on 03/10/2011. This in-service include review of the facility po	
		curtains around the bed			titled "Resident Rights". This	nicy
					in-service will also include revi	ew
	out proceeded to	pull the covers off			of the privacy practices such a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155695	A. BUILDING		02/11/2011
		155695	B. WING		02/11/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
חוייבהכו	DE VIII ACE			FRANKLIN ST	
RIVERSI	DE VILLAGE		ELKHA	ART, IN46516	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL			
TAG			TAG		
TAG	resident #74 expo During interview the DNS (Directorindicated the door	osing her body. on 2/11/11 at 1:50 P.M., or of Nursing Services) ors should have been rivacy curtains should	TAG	use of privacy curtains and cle doors during personal care ar medication and treatment administration. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be printo place? To monitor for compliance of the corrective action, the Executive Director, Social Service Director or other designee will be responsible for completion of CQI audit tool titled "Dignity/Privacy" weekly x4, monthly x3 and then quarterly thereafter. Data will be submit to the CQI Committee for revisand follow up. Compliance Date: 03/13/2011	bate DATE DATE DATE DATE DATE DATE

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/11/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0164	2/8/11 at 4:30 p.m. obtain a drop of blod an accu-check process insulin injection, wire resident's room, result ower half of Reside and visible from the the privacy curtain to the room. 4. On 2/8/11 at 4:55 to not close the reside providing care to Reside abdomen and lower being exposed and with administered med (a tube placed in the	ation administration on , LPN # 5 was observed to od from Resident #45 during edure and also to administer an thout closing the door to the alting in the abdomen and ent #45's body being exposed entilway. LPN #5 had closed between the two residents in a specific period of the following exposed entilway. LPN # 6 was observed dent's door while esident # 67, resulting in the half of Resident #67's body risible from the hallway. LPN dications by gastrostomy tube abdomen used to provide the himent and medications).	F01	64	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provide that each resident has the right personal privacy and confidentiality in regards to personal care and medical treatment. Resident # 80, resident # 74, resident # 67, and resident # 4 experienced no negative outch as a result of this finding. Any identified staff members will be thoroughly in-serviced and re-educated on resident dignit. How will you identify other residents having the potentiate to be affected the same deficient practice and what corrective action will be take All residents have the potentiate be affected by this finding and be identified through routine/ random nurse rounds. Any concerns identified will be corrected immediately. What measures will be put implace or what systemic changes you will make to ensure that the deficient practice does not recur? An all staff in-service will be hon 03/10/2011. This in-service include review of the facility putitled "Resident Rights". This in-service will also include review of the privacy practices such as the provided review of the privacy practices such as the provided review of the privacy practices such as the provided review of the privacy practices such as the provided review of the privacy practices such as the privacy practices and the privacy practices are provided to the privacy practices as the privacy practices are provided to the privacy practice.	er nt to 45 ome e y. al en? al to i will olicy iew

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/11/2011	
	ROVIDER OR SUPPLIER		1400 W	ADDRESS, CITY, STATE, ZIP CODI V FRANKLIN ST ART, IN46516	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
				use of privacy curtains an doors during personal car medication and treatment administration. How will the corrective action(s) be monitored to ensure the deficient prace will not recur, i.e. what quassurance program will into place? To monitor for compliance corrective action, the Exerpirector, Social Service Dor other designee will be responsible for completion CQI audit tool titled "Dignity/Privacy" weekly xumonthly x3 and then quar thereafter. Data will be sut to the CQI Committee for and follow up. Compliance Date: 03/13/2	ce and ctice quality be put e of this cutive currector, n of the ct-4, terly bmitted review		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DING		COMPL	ETED
		155695	A. BUIL B. WING			02/11/2	011
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
DIVEDOI	DE VILLAGE				FRANKLIN ST		
KIVERSI	DE VILLAGE			ELKHA	RT, IN46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0224	Based on observa	ation, interviews, and	F02	24	F 0224What corrective		03/13/2011
SS=D	record review, th	e facility failed to ensure			action(s) will be accomplished	ed	
	a resident was no	ot mistreated during care,			for those residents found to		
		ise to the inner right			have been affected by the		
	_	11 residents who			deficient practice? It is the practice of this provider to		
	=	bruising in a sample of			develop and implement policie	۱۹	
					and procedures that prohibit		
	18. (Resident #4	·8).			mistreatment, neglect, and abo	use	
					of residents and misappropriat		
	Finding includes	:			of resident's property. It is also		
					the practice of this provider that	at	
	Following the Gi	oup Interview, on			all alleged violations involving	_	
	02/08/11 betwee:	n 9:15 a.m. and 10:15			mistreatment, neglect, or abus including injuries of unknown	se	
	a.m Resident #4	18 indicated an area of			source and misappropriation of	ıf	
	· ·	ght inner forearm above			resident property are reported		
	-	ea was observed as deep			immediately to the administrat	or	
		•			of the facility or other designed	•	
		or and measuring			and to other officials in		
		cm (centimeters) X 4 cm			accordance with state law		
		#48 indicated she had			through established procedure		
	-	se Tuesday morning,			Resident # 48's identified bruis has resolved. All direct care st		
	02/08/11, and be	lieved the bruise			have been updated on her cur		
	happened during	a transfer with bathing			status and level of assistance		
	on Friday, 02/04	/11, while assisted by a			required for transfers and care	:.	
	•	ified Nursing Assistant).			How will you identify other		
	`	icated she was uncertain,			residents having the potentia	al	
		hower occurred, "early			to be affected the same		
	•	•			deficient practice and what	_	
		esident indicated the			corrective action will be take	n?	
		n't realize how easily I			All residents are at risk to be		
	bruise."				affected by this finding. An all staff in-service will be held on		
					03/10/2011. This in-service will	l l	
	The record for R	esident #48 was reviewed			include review of the facility po		
	on 02/10/11 at 2:	50 p.m. The record			and procedure titled, "Abuse	-	
		dent had diagnoses			Prohibition, Reporting and		
		t limited to, peripheral			Investigation". Any allegation of	or	
		tow to, perspiratur			statement regarding resident		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION		A. BUI	LDING			
		155695	B. WIN			02/11/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DI) (EDG)	551411465			1	FRANKLIN ST		
RIVERSI	DE VILLAGE			LLKHA	ART, IN46516		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	neuropathy, PVD	(Peripheral Vascular			abuse or mistreatment will be		
	Disease: poor cir	culation/blood			reported immediately to the Administrator and DNS. The		
	perfusion), pacen	naker, and osteoporosis.			facility will immediately initiate	a	
	Review of the mo	ost recent MDS			full investigation as well as		
	(Minimum Data	Set) assessment indicated			ensure notification to the MD,		
	Resident #48 was	s slightly cognitively			family, ISDH, and other agend		
	impaired and req				as outlined in the facility policy		
		or more for transfers			What measures will be put in	to	
		chair. The MDS indicated			place or what systemic changes you will make to		
	Resident #48 req				ensure that the deficient		
	1	staff with bathing.			practice does not recur? A		
		•			comprehensive head to toe		
		CNA Worksheet", dated			assessment is completed on		
	"02/04/2011: 10				admission, re-admission, and		
		eived showers on			transfer/discharge and at leas weekly by the Charge Nurses.		
	Tuesdays and Fri	idays during day shift.			Any new findings such as skin		
					tears, bruising, etcwill be		
	Interview with th	ne resident's POA (Power			documented in the clinical rec	ord.	
	of Attorney), on	02/10/11 at 1:50 p.m.,			In addition, residents who rece	eive	
	indicated the faci	ility notified the POA by			assistance with bathing and		
	phone on 02/07/1	11 at 10:30 p.m. of an			toileting care will be observed daily by the nursing staff and a	nov.	
	area of bruising of	on the right arm of			new areas of concern noted w		
		he POA believed, from			be reported to the Charge Nur		
		esident #48, the area			for further assessment. The		
		n day shift on Friday,			facility will immediately initiate		
	02/04/11.	rady sinit on Friday,			internal investigation process		
	02/04/11.				determine the probable cause and to ensure proper follow up		
	A converse UEA	CH ITV INCIDENT			How will the corrective	·	
	1	CILITY INCIDENT			action(s) be monitored to		
		ORM", was provided by			ensure the deficient practice		
		r on 02/10/11 at 2:50			will not recur, i.e. what qualit		
	1 ^	, the Administrator			assurance program will be p		
		n was faxed to the ISDH			into place? The DNS or other		
	(Indiana State De	epartment of Health) on			designee will be responsible for completion of the CQI audit to		
	02/10/11 and the	investigation was			titled, "Abuse Prohibition and		
					,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	I DING		COMPLETED	
		155695	B. WIN			02/11/2	011
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF PROVIDER OR SUPPLIER				1	FRANKLIN ST		
RIVERSI	DE VILLAGE		ELKHART, IN46516				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	complete. The A	Administrator indicated			Investigation" and "Abuse" we	ekly	
	becoming aware	of the incident following			x4 then monthly x3 and then quarterly thereafter to monitor		
	the group meetin	g during the morning of			ongoing compliance. Any trend		
	02/08/11.				or findings will be submitted to		
					CQI Committee for review and		
	Review of a forn	n titled			follow up. Compliance date:		
	"RESIDENT/FA				03/13/2011		
		EVANCE FORM", acern was received on					
	1	Consultant RN for the					
	corporation. Rev	iew of the form					
	indicated:						
	"Date of Concert						
	"Time of Concer	n: 2030 (8:30 p.m.)"					
	"Date Concern R	deceived: 02/09/11": "on					
	02/09/11 SS (Soc	cial Services) and					
	Nursing (name)	spoke c (with) (Resident					
	#48 name) & (an	d) daughter (name).					
	1	tated 'CNA, he had to get					
	'	hower & he held my arm					
		ent) 'just doesn't like his					
	`	nt) stated, 'so many can					
	get me up & are	•					
	got me up & are	501110.					
	Further investiga	tion remarks indicated					
		unable to identify the					
		yond gender. Attached to					
	l -	_					
	the investigation were two written statements, from an LPN and a CNA, both female, and dated 02/07/11. There was no further information to indicate the facility						
		-					
		staff who were working					
	on the day of the	alleged incident.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011	
	PROVIDER OR SUPPLIER		1400 W	ADDRESS, CITY, STATE, ZIP COE FRANKLIN ST RT, IN46516)E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	PROHIBITION, REPO (February 2010)", provo 2/07/11, following the "It is the policy of Ame protect residents from sexual abuse, verbal a involuntary seclusion, in property and/or funds." "Abuse is the willful infoonfinement, intimidating physical harm or pain of " Neglect-failure to pronecessary to avoid phy facility staff fails to more of resident care and seprovided as needed by "5. All abuse allegation Executive Director immore responsible for coordinating of abuse allegations, a and procedures are followed." 7. The Executive Director immore procedures are followed.	liction of injury, unreasonable on or punishment with resulting or pain, or mental anguish" ovide goods and services visical harm,Neglect occurs when nitor and/or supervise the delivery ervices to assure that care is the residents" ens/abuse must be reported to the nediately, and to the resident's 24 hours of the report ctor is the designated individual nating all efforts in the investigation and for assuring that all policies lowed" etcor/designee will report all which include abuse, within 24 the Long Term Care Division of the				

PRINTED: 03/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLE	COMPLETED	
		155695	B. WIN			02/11/20)11	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			l	/ FRANKLIN ST			
RIVERSI	DE VILLAGE			l	RT, IN46516			
			_					
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE	
F0225		ation, interviews, and	F02	25	F0225		03/13/2011	
SS=D	record review, th	e facility failed to			What corrective action(s) will	'		
	immediately repo	ort and thoroughly			be accomplished for those residents found to have been			
	investigate an all	egation of mistreatment			affected by the deficient	'		
	-	ise, for 1 of 11 residents			practice?			
	_	stained falls or bruising			It is the practice of this provide	er to		
		Resident #48).			develop and implement policie			
	iii a saiiipie oi 16	6. (Resident #48).			and procedures that prohibit			
	D: 1: : 1 1				mistreatment, neglect, and abo			
	Finding includes	:			of residents and misappropriat			
					of resident's property. It is also			
	•	roup Interview, on			the practice of this provider that all alleged violations involving	1		
	02/08/11 between	n 9:15 a.m. and 10:15			mistreatment, neglect, or abus	e l		
	a.m., Resident #4	18 indicated an area of			including injuries of unknown			
		ght inner forearm above			source and misappropriation o	f		
		ea was observed as deep			resident property are reported			
	red-purple in col	•			immediately to the administrate			
		cm (centimeters) X 4 cm			of the facility or other designed	•		
	* * *	#48 indicated she had			and to other officials in accordance with state law			
					through established procedure			
	-	se Tuesday morning,			Resident # 48's identified bruis			
	02/08/11, and be				has resolved. All direct care st			
	happened during	a transfer with bathing			have been updated on her cur	rent		
	on Friday, 02/04/	/11, while assisted by a			status and level of assistance			
	male CNA (Certi	ified Nursing Assistant).			required for transfers and care			
	Resident #48 ind	icated she was uncertain,			How will you identify other	. 1		
		hower occurred, "early			residents having the potentia to be affected the same	11		
	_	esident indicated the			deficient practice and what			
	_	n't realize how easily I			corrective action will be take	_{n?}		
	bruise."	in croanize now easily i			All residents are at risk to be			
	oruise.				affected by this finding.			
	m 10 =				An all staff in-service will be he	eld		
		esident #48 was reviewed			on 03/10/2011. This in-service			
	on 02/10/11 at 2:50 p.m. The record				include review of the facility po	olicy		
	indicated the resident had diagnoses			and procedure titled, "Abuse				
	including, but no	t limited to, peripheral			Prohibition, Reporting and Investigation. Any allegation of	,		
	-				I IIIVosugauoii . Aiiy aliegauoii ("		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WWYP11 Facility ID: 003075

If continuation sheet

Page 16 of 65

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155695	B. WIN			02/11/20	011
		<u> </u>	1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			l ₁₄₀₀ w	FRANKLIN ST		
RIVERSI	IDE VILLAGE			1	RT, IN46516		
(X4) ID	CHMMADVE	TATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110				1710	statement regarding resident		DITTE
) (Peripheral Vascular			abuse or mistreatment will be		
	Disease: poor cir				reported immediately to the		
		maker, and osteoporosis.			Administrator and DNS. The		
	Review of the m				facility will immediately initiate	а	
	(Minimum Data	Set) assessment indicated			full investigation as well as		
	Resident #48 wa	s slightly cognitively			ensure notification to the MD,		
	impaired and red	juired extensive			family, ISDH, and other agence as outlined in the facility policy		
	assistance of two	o or more for transfers			What measures will be put in		
	from the bed to a	chair. The MDS indicated			place or what systemic		
	Resident #48 red				changes you will make to		
		e staff with bathing.			ensure that the deficient		
		•			practice does not recur?		
		CNA Worksheet", dated			A comprehensive head to toe		
		a.m.", indicated			assessment is completed on		
		eived showers on			admission, re-admission, and	.	
	Tuesdays and Fr	idays during day shift.			transfer/discharge and at leas weekly by the Charge Nurses.		
					Any new findings such as skin		
	Interview with the	ne resident's POA (Power			tears, bruising, etcwill be	·	
	of Attorney), on	02/10/11 at 1:50 p.m.,			documented in the clinical rec	ord.	
		ility notified the POA by			In addition, residents who rece	eive	
		11 at 10:30 p.m. of an			assistance with bathing and		
	1 ^	on the right arm of			toileting care will be observed		
		he POA believed, from			daily by the nursing staff and a new areas of concern noted w		
		· · · · · · · · · · · · · · · · · · ·			be reported to the Charge Nur		
		esident #48, the area			for further assessment. The		
	1	n day shift on Friday,			facility will immediately initiate	an	
	02/04/11.				internal investigation process	to	
					determine the probable cause		
	A copy of a "FA	CILITY INCIDENT			and to ensure proper follow up).	
	REPORTING FO	ORM", was provided by			How will the corrective		
		or on 02/10/11 at 2:50			action(s) be monitored to		
		e, the Administrator			ensure the deficient practice will not recur, i.e. what qualit		
	1 ^	m was faxed to the ISDH			assurance program will be p	- 1	
					into place?		
	'	epartment of Health) on			The DNS or other designee w	ill	
	02/10/11 and the	investigation was			be responsible for completion		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155695	A. BUILDIN	G		02/11/2011		
		100000	B. WING	DDF=	DDDD00 0000 000	02/11/2	011	
NAME OF I	PROVIDER OR SUPPLIER		l l		DDRESS, CITY, STATE, ZIP CODE			
RIVERSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516					
(X4) ID		FATEMENT OF DEFICIENCIES					(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE	
	complete. The A	dministrator indicated			the CQI audit tool titled, "Abus			
	becoming aware	of the incident following			Prohibition and Investigation" a			
	the group meetin	g during the morning of			"Abuse" weekly x4 then month x3 and then quarterly thereafte			
	02/08/11.				monitor for ongoing complianc			
					Any trends or findings will be			
	Review of a form	n, titled,			submitted to the CQI Committee for review and follow up.	ee		
	"RESIDENT/FA				Compliance date: 03/13/2011			
		EVANCE FORM",			•			
		cern was received on						
		Consultant RN for the						
	corporation. Rev	iew of the form						
	indicated:	00 (0 = /4.4 !!						
	"Date of Concerr							
		n: 2030 (8:30 p.m.)"						
		eceived: 02/09/11": "on						
	`	cial Services) and						
	1	spoke c (with) (Resident						
	,	d) daughter (name). ated 'CNA, he had to get						
	l '	hower & he held my arm						
		ent) 'just doesn't like his						
	`	nt) stated, 'so many can						
	get me up & are	•						
	greate up to the	<i>G</i> - · - ·						
	Further investiga	tion remarks indicated						
		unable to identify the						
		ond gender. Attached to						
	I -	were two written						
	statements, from	an LPN and a CNA, both						
	female, and dated	d 02/07/11. There was no						
	further information	on to indicate the facility						
	had interviewed	staff who were working						
	on the day of the	alleged incident.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155695	A. BUII B. WIN			02/11/2011	
NAME OF I	ADOLUDED OD GLIDDI IED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		1400 W	FRANKLIN ST		
	DE VILLAGE			ELKHAI	RT, IN46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	PROHIBITION, REPOI (February 2010)", prov 02/07/11, following the "It is the policy of Amer protect residents from sexual abuse, verbal a involuntary seclusion, a property and/or funds." "Abuse is the willful inficonfinement, intimidatiphysical harm or pain of "Neglect-failure to princessary to avoid phy facility staff fails to mor of resident care and seprovided as needed by "5. All abuse allegation Executive Director imm representative within 6. The Executive Director individuals and procedures are fol 7. The Executive Director unusual occurrences, in the province of the prov	liction of injury, unreasonable on or punishment with resulting or pain, or mental anguish" ovide goods and services visical harm,Neglect occurs when nitor and/or supervise the delivery ervices to assure that care is vithe residents" ns/abuse must be reported to the nediately, and to the resident's 24 hours of the report ctor is the designated individual eating all efforts in the investigation and for assuring that all policies lowed" ctor/designee will report all which include abuse, within 24 the Long Term Care Division of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE : COMPL 02/11/20	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ FRANKLIN ST		
	DE VILLAGE				RT, IN46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
F0226		ation, interviews, and	F02		F 0226What corrective		03/13/2011
			102	20	action(s) will be accomplished	ed	03/13/2011
SS=D		e facility failed to follow			for those residents found to		
	their abuse preve	* *			have been affected by the		
		ard to the thorough			deficient practice? It is the		
	_	bruise incurred during			practice of this provider to		
		1 of 11 residents who			develop and implement policie and procedures that prohibit	s	
		bruising in a sample of			mistreatment, neglect, and abo	ise	
	18. (Resident #4	8).			of residents and misappropriat		
					of resident's property. It is also		
	Finding includes:	:			the practice of this provider that	at	
					all alleged violations involving		
		cy and Procedure, titled, "ABUSE			mistreatment, neglect, or abus including injuries of unknown	е	
	,	RTING, AND INVESTIGATION rided by the Administrator on			source and misappropriation o	ıf	
		Entrance Conference, indicated:			resident property are reported	.	
	"It is the policy of Amer	ican Senior Communities to			immediately to the administrate	or	
	protect residents from a	abuse including physical abuse,			of the facility or other designed	,	
		buse, mental abuse, neglect,			and to other officials in		
	property and/or funds."	and misappropriation of resident			accordance with state law		
		iction of injury, unreasonable			through established procedure Resident # 48's identified bruis		
		on or punishment with resulting or pain, or mental anguish"			has resolved. All direct care st		
	"Neglect-failure to pro	ovide goods and services			have been updated on her cur		
		sical harm,Neglect occurs when hitor and/or supervise the delivery			status and level of assistance		
	of resident care and se	rvices to assure that care is			required for transfers and care		
	provided as needed by	the residents"			How will you identify other	.	
	"5. All abuse allegation	ns/abuse must be reported to the			residents having the potentia to be affected the same	"	
		nediately, and to the resident's			deficient practice and what		
	representativewithin 2	24 hours of the report			corrective action will be take	n?	
		ctor is the designated individual			All residents are at risk to be		
	•	ating all efforts in the investigation nd for assuring that all policies			affected by this finding. An all		
	and procedures are foll				staff in-service will be held on	.	
	7. The Executive Direc	ctor/designee will report all			03/10/2011. This in-service will include review of the facility po		
		which include abuse, within 24			and procedure titled, "Abuse	поу	
	hours of discovery, to the Long Term Care Division of the Indiana State Department of Health"				Prohibition, Reporting and		
	maiana otate Departint	on or realis			Investigation". Any allegation of	or	
					statement regarding resident		
			1		i .	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SUR COMPLETE	
AND PLAN	OF CORRECTION		A. BUI	LDING		02/11/2011	
		155695	B. WIN			02/11/201	ı
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DI) (EDG)	551411465			1	FRANKLIN ST		
RIVERSI	DE VILLAGE			ELKHA	ART, IN46516		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		roup Interview, on			abuse or mistreatment will be		
	02/08/11 between	n 9:15 a.m. and 10:15			reported immediately to the Administrator and DNS. The		
	a.m., Resident #4	18 indicated an area of			facility will immediately initiate	a	
	bruising to the rig	ght inner forearm above			full investigation as well as		
	the wrist. The are	ea was observed as deep			ensure notification to the MD,		
	red-purple in col	or and measuring			family, ISDH, and other agence		
		cm (centimeters) X 4 cm			as outlined in the facility policy		
	1 * *	#48 indicated she had			What measures will be put in place or what systemic	το	
		se Tuesday morning,			changes you will make to		
	02/08/11, and bel				ensure that the deficient		
	· ·	a transfer with bathing			practice does not recur? A		
	''	· ·			comprehensive head to toe		
	l * .	/11, while assisted by a			assessment is completed on		
	`	ified Nursing Assistant).			admission, re-admission, and		
		icated she was uncertain,			transfer/discharge and at leas weekly by the Charge Nurses.		
	· ·	hower occurred, "early			Any new findings such as skin		
	morning." The re	esident indicated the			tears, bruising, etcwill be		
	male CNA "does	n't realize how easily I			documented in the clinical rec	ord.	
	bruise."				In addition, residents who rece	eive	
					assistance with bathing and		
	The record for Ro	esident #48 was reviewed			toileting care will be observed daily by the nursing staff and a	anv	
	on 02/10/11 at 2:	50 p.m. The record			new areas of concern noted w		
		dent had diagnoses			be reported to the Charge Nur		
		t limited to, peripheral			for further assessment. The		
	•) (Peripheral Vascular			facility will immediately initiate		
	Disease: poor cir	` 1			internal investigation process		
		naker, and osteoporosis.			determine the probable cause and to ensure proper follow up		
	*				How will the corrective	,. 	
	Review of the mo				action(s) be monitored to		
	1	Set) assessment indicated			ensure the deficient practice		
		s slightly cognitively			will not recur, i.e. what qualit		
	impaired and req				assurance program will be p		
		or more for transfers			into place? The DNS or other		
	from the bed to c	hair. The MDS indicated			designee will be responsible for		
	Resident #48 req	uired moderate			completion of the CQI audit to titled, "Abuse Prohibition and	UI	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155695	A. BUILD	ING		02/11/2011		
		100090	B. WING			02/11/2	011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
RIVERSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516					
		EATEMENT OF DEPLOYENCIES			,		075	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	Di	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE	
		staff with bathing.			Investigation" and "Abuse" wee	ekly		
		CNA Worksheet", dated			x4 then monthly x3 and then	·		
	"02/04/2011: 10				quarterly thereafter to monitor			
		eived showers on			ongoing compliance. Any trend or findings will be submitted to			
		idays during day shift.			CQI Committee for review and			
		, &,			follow up. Compliance date:			
	Interview with th	ne resident's POA (Power			03/13/2011			
		02/10/11 at 1:50 p.m.,						
	l • • • • • • • • • • • • • • • • • • •	ility notified the POA by						
		11 at 10:30 p.m. of an						
	l *	on the right arm of						
		he POA believed, from						
		esident #48, the area						
		n day shift on Friday,						
	02/04/11.	•						
	A copy of a "FA	CILITY INCIDENT						
	REPORTING FO	ORM", was provided by						
	the Administrato	r on 02/10/11 at 2:50						
	p.m. At this time	, the Administrator						
	indicated the form	m was faxed to the ISDH						
	(Indiana State De	epartment of Health) on						
	02/10/11 and the	investigation was						
	complete. The A	Administrator indicated						
	becoming aware	of the incident following						
	the group meetin	g during the morning of						
	02/08/11.							
	Review of a form	n, titled,						
	"RESIDENT/FA	MILY						
	CONCERN/GRI	EVANCE FORM",						
	indicated the con	icern was received on						
	02/09/11 by the 0	Consultant RN for the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155605			(X2) MUI A. BUILI		NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011	
		155695	B. WING			02/11/2	UII
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RIVERSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG				TAG	DEFICIENC!)		DATE
	corporation. Rev indicated:	iew of the form					
	"Date of Concern	02/07/11"					
		n: 2030 (8:30 p.m.)"					
		eceived: 02/09/11": "on					
		cial Services) and					
	,	spoke c (with) (Resident					
	O \	d) daughter (name).					
	, , , , , , , , , , , , , , , , , , ,	ated 'CNA, he had to get					
	` ′	hower & he held my arm					
		ent) 'just doesn't like his					
	,	nt) stated, 'so many can					
	get me up & are						
	Further investiga	tion remarks indicated					
	the resident was	unable to identify the					
	staff member bey	yond gender. Attached to					
	the investigation	were two written					
	statements, from	an LPN and a CNA, both					
	female, and dated	d 02/07/11. There was no					
	further informati	on to indicate the facility					
	had interviewed	staff who were working					
	on the day of the	alleged incident.					
	3.1-28(a)						
	J.1-20(a)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLE	
		155695	B. WING			02/11/20	11
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST RT, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F0241	facility failed to demaintained during by direct care state cell phones, engate conversations with communicating with providing direct providents and family confidentially into the providential interview individual resident who represented a units. Confidential who represented a units. Confidential indicated direct care staff providential indicated direct care staff providential indicated direct care staff providential indicated direct conversations with resident receiving indicated direct conversations with the providential direct conversation with the providential direct conversation with the providential direct convers	th each other, and not with residents while personal care. This ed 5 of 8 residents who up meeting and/or milies who were erviewed (Resident Q). 1 and 02/11/11, views were conducted eting of residents, into and family members residents residing on 3 of ential interviews and 5 of ential int	F02	41	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provide promote care for residents in a manner and in an environment that maintains or enhances ear resident's dignity and respect if ull recognition of his or her individuality. There were no specific resider identified in regards to this finding. How will you identify other residents having the potentiat to be affected the same deficient practice and what corrective action will be take All residents have the potentiat be affected by this finding. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? An all staff in-service will be conducted on 03/10/2011. This in-service will include review of the facility policy titled "Reside Rights". This in-service will als include review of the procedur for maintaining dignity during resident care. Staff will be re-educated regarding practice such as engaging in personal conversations with co-workers while providing direct personal care to residents. All staff will as a care to residents.	er to a t ch in ts If to to s f int o e es	03/13/2011

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	A. BUILDING B. WING	CONSTRUCTION	COMPLETED 02/11/2011
	PROVIDER OR SUPPLIER DE VILLAGE		STREET 1400 \	ART, IN46516	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	was observed wir cognitively impa were alert and or interview with R Some of those powhat's going on not be answering them. " Interview with the corporation, the I Services), and the 02/10/11 at 9:00 facility did not re-	th residents who were ired as well as those who iented. A confidential esident Q indicated, " por people may not know but they (staff) should a phones and talking over the Consultant RN for the DNS (Director Nursing e Administrator, on a.m., indicated the putinely follow-up on accility in regards to		be re-educated on facility policy regarding cell phone use. How will the corrective action(s) be monitored to ensure the deficient practic will not recur, i.e. what qual assurance program will be into place? To monitor for ongoing compliance of this corrective action the ED, SSD, or other designee will be responsible completion of the CQI audit to titled, "Dignity and Privacy", weekly x4 and then monthly thereafter. Data will be submit to the CQI Committee for revand follow up. Compliance Date: 03/13/201	licy lee lity put for ool itted riew

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155695	B. WIN			02/11/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
DIVEDSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516				
KIVEKSI	DE VILLAGE			LLINIA			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)					DATE
F0253	Based on observa	ation and interview, the	F02	53	F 0253		03/13/2011
	facility failed to	provide necessary service			What corrective action(s) will	·	
	to ensure a sanitary and clean				be accomplished for those		
	environment in r	egard to cleaning and			residents found to have been	1	
		et grab bars and cleaning			affected by the deficient practice?		
	_				It is the practice of this provide	er to	
	of the popcorn machine area. This deficiency affected 2 of 2 residents				provide necessary service to		
					maintain a sanitary, orderly an	d	
		106 and any residents			comfortable interior.		
	_	e unit or the Liberty unit			Room 106 on the Heritage Uni	it:	
	utilizing the activ	vity room popcorn			the toilet grab bar has been		
	machine.				replaced.		
				The popcorn machine and surrounding cart has been			
	Findings include	:			cleaned.		
	Č				No specific residents were		
	1 During the er	nvironmental tour on			identified to be affected by this	;	
	_				finding.		
		M., accompanied by the					
		the housekeeping			How will you identify other		
	supervisors, the f	following was observed:			residents having the potentia	ıl	
					to be affected the same		
	In room 106 on t	he Heritage unit, the area			deficient practice and what		
	behind the toilet	seat, where the toilet			corrective action will be take		
		ched, was filled with			All residents have the potentia be affected by this finding.	ו נט	
	_	thite paint. When			What measures will be put in	to	
		me, the maintenance			place or what systemic		
	•				changes you will make to		
	-	ated the bars where			ensure that the deficient		
	_	te enamel paint and the			practice does not recur?		
		ner was causing the paint			An all staff in-service will be he		
	to chip off.				on 03/10/2011. This in-service		
					include review of the procedur		
	2. The popcorn	machine in the activity			regarding routine cleaning, rep and maintenance request slips		
	room was sitting	on a cart. There was			All staff will be informed of the		
	food debris and o				routine cleaning schedule for t		
		popcorn machine. There			popcorn machine.	-	
	sarrounding the j	popositi maciniic. There			How will the corrective		
			1		I		

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	popcorn machine	the shelf underneath the e. The housekeeping ated the popcorn machine sed.		action(s) be monitored to ensure the deficient practic will not recur, i.e. what qual assurance program will be into place? Ongoing compliance with this corrective action will be moni through completion of the CG audit tool titled, "Facility, Environmental Review". This audit tool will be completed weekly x4 and then monthly thereafter. The Executive Director, Maintenance Direct Activity Director, or other designee is responsible for program compliance. Date w submitted to the CQI Commit for review and follow up. Completion Date: 03/13/2011	ity but stored all or, ill be stee		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155695	A. BUII	LDING		02/11/2011
		199099	B. WIN			02/11/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
חויירם סו	DE \		1400 W FRANKLIN ST ELKHART, IN46516			
RIVERSI	DE VILLAGE			ELKHA		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	700	TAG		DATE
F0279		ews and record reviews,	F02	79	F0279 What corrective action(s) will	03/13/2011
SS=D	-	to develop a care plan			be accomplished for those	'
		it with an intravenous			residents found to have beer	,
	port for chemothe	erapy in a sample of 18.			affected by the deficient	
	(Resident #30)				practice?	
					It is the practice of this provide	
	Findings include:				use the results of the assessm	• • • • • • • • • • • • • • • • • • •
	C				to develop, review and revise resident's comprehensive plan	
	The clinical reco	rd of Resident # 30 was			care.	
	reviewed on 2/9/	11 at 9:00 a.m., and			Resident # 30's care plan has	
		dent had diagnoses			been reviewed and updated to)
		t limited to, low grade			reflect her current status.	
	•	mphoma. Resident #30			How will you identify other	
		•			residents having the potentia	
	_	emotherapy with the			to be affected the same deficient practice and what	
	most recent dose	documented as 02/08/11.			corrective action will be take	n?
	The nurses notes dat	ted 12/10/10, indicated the			All residents are at risk to be	
		placed for chemotherapy.			affected by this finding. All	
	resident nua u port p	ineed for enemerapy.			resident's care plans will be	
	There was no care p	lan for the resident's			reviewed and revised during the	
	intravenous port.				next 90 days by the IDT team ensure accuracy and	to
	0.0/0/44				appropriateness.	
		m., the Minimum Data Set Coordinator was interviewed			What measures will be put in	to
		plan for the Intravenous port			place or what systemic	
		The MDS Coordinator			changes you will make to	
		t develop a care plan, and the			ensure that the deficient	
	resident should have	had a care plan in place for			practice does not recur? All disciplines will participate in	,
	the intravenous port.				the development and ongoing	'
	0.04044	1 DVG (D)			revisions to the plan of care. T	he
		o.m., the DNS (Director of			24 Hour Condition Report is	
		as queried in regard to the port and the DNS indicated			reviewed daily by all discipline	s to
		ysician's order to check the			ensure information regarding	
		for signs and symptoms of			resident condition such as placement of an intravenous p	ort
	infection.				and physician order changes a	
					utilized to develop and update	
					<u> </u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155695	A. BUILDING		02/11/2011
		100000	B. WING	ADDRESS STEEL STEE	02/11/2011
NAME OF F	PROVIDER OR SUPPLIER	8	I	ADDRESS, CITY, STATE, ZIP CODE V FRANKLIN ST	
	DE VILLAGE		ELKHA	ART, IN46516	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		a.m. the Director of Nursing	TAG	each resident's plan of care. A	-
		vided Nurses Notes dated		Nursing in-service will be held	
	` / *	13/11, that indicated the nurses		3/10/2011. This in-service will	
		ently on the intravenous port.		include review of the facility p	olicy
		Nurses Notes after 1/13/11,		titled, "Care Plan Review".	
		S in regard to the intravenous		How will the corrective action(s) be monitored to	
	port.			ensure the deficient practice	
	3.1-35(a)			will not recur, i.e. what quali	
				assurance program will be p	ut
				into place? The CQI audit tool titled, "Care	
				Plan Updating" will be comple	
				weekly x4, monthly x3 and the	
				quarterly thereafter by the MD	
				Coordinator and other design	
				Findings will be submitted to t CQI Committee for review and	
				follow up.	'
				The DNS, MDS Coordinator	
				and/or designee will be	
				responsible for program	
				compliance. Compliance Date: 03/13/2011	
				05/11/2011	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/11/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0282	observation, the physician orders (Residents #67, #correctly transcri medication (Resifollow care plans recommendation to prevent falls (I This deficiency a reviewed for follow and care plans in Findings include 1. The clinical was reviewed on and indicated diabut were not limit vascular accident (congestive heart mellitus. A physician's ordindicated a hepat There was no dot the laboratory test During interviewed the DNS (Directed indicated the hep done as ordered.	dent #45), and failed to in regard to following is for resident safety and Residents #87, #17). Iffected 6 of 18 residents owing physician orders a sample of 18. record of Resident #67 2/10/11 at 10:25 A.M., gnoses which included, ted to, CVA (cerebral to stroke), CHF failure) and diabetes ler, dated 12/20/10, ic panel was to be done. cumentation to indicate	F02	82	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provided that services must be provided qualified persons in accordance with each resident's written play of care. Residenti# 67's physician was notifed and new lab orders were received. Residenti# 33 has been discharged from the facilitity Residenti# 74's physician was notifed and labs were drawn as ordered. Residenti# 45's physician was notifed of medication discrepancy. The physician is aware of currenti stiatius and is aware of currenti coumadin dosage. Residenti# 87 has been discharged from tihe facilitity Resident # 17's care plan has been reviewed and updated to reflect current interventions. A direct care staff have been in-serviced/re-educated on specific safety interventions lis on the care plan for this identification. None of the identified resident experienced any negative outcome as a result of this finding. How will you identify other residents having the potentia	er d by de an	03/13/2011

			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED		
		155695	B. WIN	G		02/11/2011		
NAME OF	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1400 W FRANKLIN ST				
	IDE VILLAGE		ELKHART, IN46516					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	+	TAG		DATE		
		2/9/11 at 10:10 A.M.,			to be affected the same deficient practice and what			
		admission date of			corrective action will be take	n?		
		agnoses which included,			All residents have the potentia			
	but were not limi	ited to, CHF (congestive			be affected by this finding and			
	heart failure), aoi	rtic valve disease and			be identified through a facility			
	COPD (chronic o	obstructive pulmonary			audit of the following: laborato	-		
	disease).	_ -			review, physician order review			
					and fall care plan review. These audits will ensure labs are being			
	Review of the Ja	nuary and February 2011			obtained and followed as orde	-		
		forms indicated the			physician orders have been	,		
	1 ^ -	eiving Coumadin (a blood			transcribed correctly, and fall			
		`			prevention and safety			
		ion) daily, the dosage			interventions are being follower			
	1	e PT/INR laboratory			What measures will be put in	ito		
	results.				place or what systemic			
	A physician's ord				changes you will make to ensure that the deficient			
	indicated the Cou	umadin should be held			practice does not recur?			
	until 2/7/11 and t	the PT/INR laboratory			An all nursing staff in-service	vill		
	tests should be de	one on 2/7/11, and start			be held on 03/10/2011. This			
	Coumadin 3 mg	daily on 2/7/11.			in-service will include review of	f		
		•			the following facility policies:			
	There was no doo	cumentation to indicate			"Guidelines for Lab Tracking", "Medication and Treatment			
		been done on 2/7/11 as			Administration Record" and "F	all		
		interview on 2/11/11 at			Management Program".	<u>~</u>		
	_	NS indicated the order			How will the corrective			
					action(s) be monitored to			
		n 2/7/11, had been			ensure the deficient practice			
	missed.				will not recur, i.e. what qualit			
					assurance program will be p	ut		
		record of Resident #74			into place?			
		2/9/11 at 1:40 P.M., and			To ensure ongoing compliance with this corrective action the	=		
	indicated diagnos	ses which included, but			DNS or designee will utilize th	e		
	were not limited	to, dementia and contact			following CQI audit tools:			
	dermatitis.				"Change in Condition",			
					"Laboratory and Diagnostic" a			
					"Care Plan Updating" weekly	(4		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695		A. BUILDING			survey eted 011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	A physician's ordindicated a pre-a vitamin D 25 hydrone. There was indicate the labordone. During interview	der, dated 10/11/10, Ibumin level and a droxy level were to be as no documentation to ratory tests had been on 2/11/11 at 9:30 Indicated the tests had not		IAG	and monthly thereafter. Findin will be submitted to the CQI committee for review and folloup. Compliance Date: 03/13/2011		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155695	B. WING 02/1		02/11/2	011	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t .		l			
RIVERSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0282		inical record of Resident	F02	82	F 0282	.	03/13/2011
	#87 was reviewe	ed on 2/9/11 at 2:15 p.m.,			What corrective action(s) will	'	
	and indicated the	e resident had diagnoses			be accomplished for those residents found to have been	.	
	which included,	but were not limited to,			affected by the deficient	'	
	fractured hip and	l dementia.			practice?		
					It is the practice of this provide	er	
	The Interdiscipli	nary Team progress notes			that services must be provided		
	•				qualified persons in accordance	e e	
		60/10, indicated "IDT			with each resident's written pla	an	
		Resident found on floor			of care.		
		715 (5:15 p.m.), she had			Residenti# 67's physician was		
	previously been	in recliner in TV lounge,			notifed and new lab orders were		
	and attempted to	get up per self. Resid			received.		
	(resident) had tal	b alarm to bed and w/c			Residenti# 33 has been discharged from tihe facility		
	(wheelchair). Al	larm was not placed in			Residenti# 74's physician was		
	` ') her. She was fully			notifed and labs were drawn as		
	` ′ `	s on. Resid has severe			ordered.		
	` '	(and) exhibits poor safety			Residenti# 45's physician was		
	awareness"	(and) exhibits poor safety			notifed of medication discrepancy .		
	awareness				The physician is aware of currenti		
	THE CONTRACT	. 1.10/10/10 : 1: 1			stiatius and is aware of currenti		
		ated 10/18/10, indicated			Coumadin dosage.		
		risk for falls due to hx			Residenti# 87 has been discharged		
	(history) of falls,	hx of recent hip fracture,			from tihe facility		
	requires assist w	ith mobility and transfers,			Resident # 17's care plan has		
	dx (diagnosis) de	ementiaInterventions			been reviewed and updated to reflect current interventions. A		
	`	ert staff of attempts to			direct care staff have been	"	
	transfer unassiste	•			in-serviced/re-educated on		
					specific safety interventions lis	ted	
	5 The clinical r	ecord of Resident # 45			on the care plan for this identif	ied	
					resident.		
		2/8/11 at 1:30 p.m., and			None of the identified resident	s	
		ident had diagnoses			experienced any negative		
		but were not limited to,			outcome as a result of this finding.		
	chronic atrial fib	rillation.			How will you identify other		
					residents having the potentia	ս	

			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED
		155695	B. WIN	G		02/11/2011
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF I	NO VIDEN ON SOLVEIEN		1400 W FRANKLIN ST			
RIVERSI	DE VILLAGE			ELKHA	ART, IN46516	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	The physician tel	lephone orders dated			to be affected the same	
	1/26/11 at 1930 ((7:30 p.m.), indicated			deficient practice and what	" 2
	start Coumadin t	wo milligrams one tablet			corrective action will be take All residents have the potentia	
	by mouth every of	lay.			be affected by this finding and	l l
	, ,				be identified through a facility	wiii
	The Medication	Administration Record			audit of the following: laborato	ry
		7/11 through 1/31/11,			review, physician order review	,
	` ′	dent had received			and fall care plan review. The	
					audits will ensure labs are bei	- 1
		nilligrams one tablet			obtained and followed as orde physician orders have been	ered,
	every day.				transcribed correctly, and fall	
					prevention and safety	
	The Physician's (Order Sheet (POS) dated			interventions are being follower	ed.
	February 2011, in	ndicated an order for			What measures will be put in	
	"warfarin sodium	n (Coumadin) 2 MG			place or what systemic	
		etCoumadin 2 MG			changes you will make to	
	· ·	et orally once a day"			ensure that the deficient	
	_	Coumadin dated 1/19/11			practice does not recur?	
					An all nursing staff in-service	WIII
		off and the date 1/26/11			be held on 03/10/2011. This in-service will include review of	,f
	was written in on				the following facility policies:	"
	_	e for two milligrams and			"Guidelines for Lab Tracking",	
		lso written in on the			"Medication and Treatment	
	POS.				Administration Record" and "F	all
					Management Program".	
	The MAR dated	February 2011, indicated			How will the corrective	
		farin sodium 2 (Two)			action(s) be monitored to	
		tabletCoumadin 2			ensure the deficient practice will not recur, i.e. what qualit	
	` '	tablet orally once a			assurance program will be p	- 1
	day"	motor orang ones a			into place?	
	_	Coumadin order dated			To ensure ongoing compliance	e
		e Coumadin order dated			with this corrective action the	
		crossed off, and the date			DNS or designee will utilize th	e
		ten in. The Coumadin			following CQI audit tools:	
	_	nilligrams and two tablets			"Change in Condition",	nd
	was also written	in. The Coumadin 2 mg			"Laboratory and Diagnostic" a "Care Plan Updating" weekly >	
					Care Fian Opualing weekly	\ T

l i			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		l		
		155695	B. WIN			02/11/20	, i i	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE			
RIVERSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516					
					1(1, 11(40310			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
-		ets were signed as given		_	and monthly thereafter. Finding	gs		
		/4/11 at 5:00 p.m., Also			will be submitted to the CQI	Ĭ		
		MAR was "D/C			committee for review and follo	w		
		written- clarification			up. Compliance Date: 03/13/2011			
	l ` ′	e MAR dated 2/5/11 at			Compliance Date: 03/13/2011			
	5:00 p.m., the or							
	_	give 1 tablet once a day.						
	administer 2 mg	51. 7 1 motor once a day.						
	A Medication Er	ror Report dated 2/9/11,						
		d reviewed on 2/10/11 at						
		ted "Date of error 2/1 -						
	· ·	ade during transcription						
		s. I crossed off (one) mg						
		2 mg tab (tablet) but on						
		e - Wrote give 2 tablets						
		nce daily and forgot to						
		2Nurse doing 2nd						
	ı ~	also failed to (too)How						
	was the error disc	* *						
		on 2/5 and clarified it"						
	questioned order	on 2/3 and charmod it						
	On 2/10/11 at 9·1	15 a.m., the Director of						
		s (DNS) was queried in						
		ascription error for the						
	"	s signed as given on 2/1						
		The DNS indicated the				l		
	_	d the Coumadin order						
		vrote 2 milligrams 2						
	1	rect dosage was give 2 mg				l		
		ay. The DNS also						
		s awaiting a call back						
		to had signed the MAR						
	dated 2/1 through	_						
	aatoa 2/1 milougi	11 M/ 1/ 11 1.				l		
	<u> </u>							

l	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695 A. BUILDING B. WING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	queried in regard through 2/4/11. she had looked a did not read the to administer two and went by men had received last indicated she had through 2/4/11, b	15 p.m., LPN #5 was I to the MAR dated 2/1 LPN #5 indicated when It the 2/2011 MAR she full order for the warfarin I milligrams two tablets I mory of what the resident I month. LPN #5 I signed the MAR for 2/1 I put she had only given the I igrams one tablet once a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155695	A. BUII	LDING		02/11/2011
		193099	B. WIN			02/11/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DIVEDGI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE
			E02		F 0282	
F0282		Resident #17 was	F02	82	What corrective action(s) will	03/13/2011
		07/11 at 1:00 p.m.			be accomplished for those	
		s admitted to the facility			residents found to have been	n
		diagnoses including, but			affected by the deficient	
	-	AD (Coronary Artery			practice?	
	· ·	s, CHF (Congestive			It is the practice of this provide	I
	Heart Failure), de	ementia, and depression.			that services must be provided qualified persons in accordance	
					with each resident's written pla	
	During the initial	tour, on 02/07/11,			of care.	
	between 11:00 a.	m. and 11:45 a.m., and			Residenti# 67's physician was	
	accompanied by	LPN #3, Resident #17			notifed and new lab orders were	
	was identified as	having incurred a			received.	
	significant bruise	to her posterior (back)			Residenti# 33 has been discharged	
	thigh and being o	on fall precautions. The			from tihe facilitiy Residenti# 74's physician was	
		(a tool to aid in resident			notifed and labs were drawn as	
	care), used during	`			ordered.	
	, , , , , , , , , , , , , , , , , , ,	SPECIAL NEEDS":			Residenti# 45's physician was	
		by chair & bedbed in			notifed of medication discrepancy .	
	lowest position				The physician is aware of currenti	
	10 West position	Tron shiu soons.			stiatius and is aware of currenti	
	Recident #17 was	s observed, during the			Coumadin dosage.	
		awake and atop her bed			Residenti# 87 has been discharged from tihe facility	
		lowest position. The			Resident # 17's care plan has	
		vas observed to not have			been reviewed and updated to	, [
					reflect current interventions. A	II
		front of the bed or the			direct care staff have been	
		no evidence of a bed			in-serviced/re-educated on specific safety interventions lis	ted
		ace. Observation of the			on the care plan for this identif	I
		ident #17 indicated a			resident.	
	-	le over the toilet with a			None of the identified resident	s
	bars on both side	s and a standard			experienced any negative	
	commode seat.				outcome as a result of this finding.	
					How will you identify other	
	Review of a care	plan for "06/03/10:			residents having the potentia	al

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155695	A. BUILDING		02/11/2011	
			B. WING	EFT A DEDEGG GVEN GTATE GIR CODE		
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 0 W FRANKLIN ST		
RIVERSI	DE VILLAGE		ELKHART, IN46516			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPROPRI		
TAG		LSC IDENTIFYING INFORMATION)	TAG	to be affected the same	DATE	
		k for falls and/or has had		deficient practice and what		
	•	cated, but was not		corrective action will be tak	en?	
	limited to, the fo			All residents have the potenti	I	
	"INTERVENTIC	ONS:		be affected by this finding an	•	
	02/2011: Bed ala	arm		be identified through a facility	•	
	08/02/10 Non-sk	kid strips in front of bed		audit of the following: laborate	-	
		id strips in front of chair		review, physician order review		
		F = 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2		and fall care plan review. The		
	Review of "IDT	(Interdisciplinary Team)		audits will ensure labs are be obtained and followed as ord	-	
				physician orders have been	cica,	
Progress Notes", dated 01/25/11 at 1800				transcribed correctly, and fall		
	(6:00 p.m.), indic			prevention and safety		
		bruise noted during		interventions are being follow	red.	
	shower 01/24/11	having resident sit on		What measures will be put i	nto	
	commode & ease	e herself c (with) bars on		place or what systemic		
	both sides showe	ed the bruised area		changes you will make to		
	coming in contac	et c the edge of the		ensure that the deficient		
		nursing recommending		practice does not recur? An all nursing staff in-service	القيد	
	possibility of sof	_		be held on 03/10/2011. This	WIII	
	possibility of sof	t commode seat.		in-service will include review	of	
	2.1.25(~)(2)			the following facility policies:		
	3.1-35(g)(2)			"Guidelines for Lab Tracking"	,	
				"Medication and Treatment		
				Administration Record" and "	Fall	
				Management Program".		
				How will the corrective action(s) be monitored to		
				ensure the deficient practic	e	
				will not recur, i.e. what qual	I	
				assurance program will be p	-	
				into place?		
				To ensure ongoing compliand	•	
				with this corrective action the	I	
				DNS or designee will utilize the	ne	
				following CQI audit tools: "Change in Condition",		
				"Laboratory and Diagnostic" a	and	
				"Care Plan Updating" weekly		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011		
	PROVIDER OR SUPPLIER DE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	and monthly thereafter. Find will be submitted to the CQI committee for review and fo up. Compliance Date: 03/13/20	lings	DATE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED
ANDILAN	or condection	155695	A. BUII	LDING		02/11/2011
		133033	B. WIN			02/11/2011
NAME OF F	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
DIVEDOL				1	/ FRANKLIN ST	
	DE VILLAGE			LLKHA	.RT, IN46516	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE
F0323		ervation and interview,	F03	23	F 0323	03/13/2011
	the facility failed				What corrective action(s) will be accomplished for those	1
	environment free	of hazards in regard to			residents found to have been	,
	the storage of a p	ortable oxygen (O2)			affected by the deficient	
	cylinder and resp	onse to a door alarm for			practice?	
	1 of 3 units (Heri	tage hall) in the facility.			It is the practice of this provide	
	This deficiency h	and the potential to effect			that each resident environmen	
	•	s residing on the Heritage			remains free of accident hazar as possible and each resident	I
		residents who had			receives adequate supervision	I
	emergency need				and assistive devices to preve	
	cinergency need	01 02.			falls.	
	D Dagad on road	ord review, the facility			Resident # 87 has been	
		•			discharged from the facility.	
		upervision to prevent a			The O2 cylinder has been	
		idents reviewed for falls			secured to the wall by a chain. An additional speaker was	
	in a sample of 18	. (resident #87)			installed closer to the nurse's	
					station to alert staff if the door	is
	Findings include:	:			opened.	
					How will you identify other	
	A.1. On 2/8/11 a	at 1:25 P.M., during the			residents having the potentia	al
	environment tour	, accompanied by the			to be affected the same	
	maintenance and	housekeeping			deficient practice and what corrective action will be take	n2
		rtable oxygen (O2)			All residents are at risk to be	"
) cylinder was observed			affected by this finding.	
		y room of the Heritage			What measures will be put in	to
		or was in place on the			place or what systemic	
	_	er, however the cylinder			changes you will make to	
		d or chained to the wall.			ensure that the deficient	
					practice does not recur? An all staff in-service will be he	old
		supervisor indicated the			on 03/10/2011. This in-service	
		was part of the "crash"			include review of the facility po	
	· ·	supplies to assist in			titled, "Missing Resident/Resid	lent
		nts with acute emergency			Elopement" with an emphasis	on
	,	also in the room. 37			the importance of immediate	
	residents resided	on the Heritage hall.			response to any safety alarm and/or door alarm. This in-serv	uice
					and/or door alaitii. Tiils iii-Serv	/100

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155695	A. BUII	LDING		02/11/2011	
		133033	B. WIN		A DEPENDE OF THE CORE	02/11/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST		
RIVERSI	DE VILLAGE			1	RT, IN46516		
		FATEMENT OF DEPLOIPMONE		<u>l</u> .		1 0/5	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5 COMPLE	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E DATE	
	2. The door at the opened on to a be was a key pad to alarm would sour to open without a door was pushed sounded. A laun halfway down the cupboard. She dalarm. 37 resident independently me confused, resided. At this time, the indicated a light station would incopened. Althoughoud, it could be station. Several saround the nurses respond. One Chassistant) said "we down the hall took the code in the key alarm but did not this time, the unit CNA should have.	the top of the Heritage hall all all all all all all all all al			will also include review of the policy titled, "Fall Management Program". Fall prevention and keeping the environment safe and free of hazards will also be discussed. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what qualit assurance program will be printo place? To ensure ongoing compliance with this corrective action. The DNS or designee will be responsible for completing the CQI audit tool titled "Fall Management" weekly x4 and monthly thereafter. The facility conduct Elopement Drills week x4 and then monthly thereafter Findings will be submitted to the CQI committee for review and follow up. The ED is responsible for determining the dates and time of the Elopement Drills. A CQI tool titled, "Elopement Procedu will be completed following ear elopement drill. Findings will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	will ly . ee	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI			JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155695	B. WIN			02/11/2011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER					
חוייבוסו	DEVILLACE				/ FRANKLIN ST	
RIVERSI	DE VILLAGE			ELKHA	.RT, IN46516	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0323	B. The closed cl	inical record of Resident	F03	23	F 0323	03/13/2011
	#87 was reviewe	d on 2/9/11 at 2:15 p.m.,			What corrective action(s) will	I
		resident had diagnoses			be accomplished for those	
		· ·			residents found to have beer	1
	· ·	but were not limited to,			affected by the deficient	
	fractured hip and	dementia.			practice?	
					It is the practice of this provide	
	The Interdiscipling	nary Team progress notes			that each resident environmen	
	(IDT) dated 11/3	0/10, indicated "IDT			remains free of accident hazar as possible and each resident	
	` ′	Resident found on floor			receives adequate supervision	I
		715 (5:15 p.m.), she had			and assistive devices to preve	
		in recliner in TV lounge,			falls.	
	1 1	• ,			Resident # 87 has been	
	1	get up per self. Resid			discharged from the facility.	
	(resident) had tal	alarm to bed and w/c			The O2 cylinder has been	
	(wheelchair). Al	arm was not placed in			secured to the wall by a chain.	
	recliner (c) (with) her. She was fully			An additional speaker was	
	` ′ `	on. Resid has severe			installed closer to the nurse's	
	` ′	(and) exhibits poor safety			station to alert staff if the door	IS
		(and) exhibits poor safety			opened.	
	awareness"				How will you identify other residents having the potentia	,
					to be affected the same	XI
		ated 10/18/10, indicated			deficient practice and what	
	"resident is at r	risk for falls due to hx			corrective action will be take	n?
	(history) of falls,	hx of recent hip fracture,			All residents are at risk to be	
	l '	ith mobility and transfers,			affected by this finding.	
	· •	ementiaInterventions			What measures will be put in	to
	` • ′	ert staff of attempts to			place or what systemic	
	transfer unassiste	•			changes you will make to	
	uansier unassiste	ču			ensure that the deficient	
					practice does not recur?	
	3.1-45(a)(1)				An all staff in-service will be he	
	3.1-45(a)(2)				on 03/10/2011. This in-service	
					include review of the facility po	- I
					titled, "Missing Resident/Resident Elopement" with an emphasis	I
					the importance of immediate	011
					response to any safety alarm	
					and/or door alarm. This in-serv	vice

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011		
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
				will also include review of the policy titled, "Fall Manageme Program". Fall prevention an keeping the environment safe and free of hazards will also discussed.	nt d e		
				How will the corrective action(s) be monitored to ensure the deficient practic will not recur, i.e. what qual assurance program will be into place? To ensure ongoing compliant with this corrective action. The DNS or designee will be responsible for completing the CQI audit tool titled "Fall Management" weekly x4 and monthly thereafter. The facility conduct Elopement Drills were x4 and then monthly thereafter Findings will be submitted to CQI committee for review an follow up. The ED is responsible for determining the dates and time of the Elopement Drills. A CQI tool titled, "Elopement Processial be completed following elopement drill. Findings will submitted to the CQI Commit for review and follow up. Compliance Date: 03/13/201	tity put ce ne ty will ekly er. the d mes QI dure" ach be ttee		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE : COMPL 02/11/20	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF P	ROVIDER OR SUPPLIER				FRANKLIN ST		
	DE VILLAGE			ELKHA	RT, IN46516		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG			E02		F 0333		
F0333		review and interview, the	F03	33	What corrective action(s) will	.	03/13/2011
SS=D	_	assure Insulin coverage			be accomplished for those	<u> </u>	
		l as ordered for 14 of 18			residents found to have been	,	
		inistration reviewed, for 1			affected by the deficient		
		eiving insulin in a			practice?		
	sample of 18. (Re	esident #18)			It is the practice of this provide ensure that all residents be fre		
					of any significant medication	E	
	Finding includes:	:			errors.		
					Resident # 18 continues on		
	The record of resident #18 was reviewed on 02/11/11 at 10:35 a.m. Resident #18				sliding scale coverage. New		
					physician orders were received use the same sliding scale for		
	had diagnoses including, but not limited				blood glucose results. This	all	
	to, diabetes, anemia, depression, and				resident did not experience an	y	
	chronic renal dise	ease.			negative outcome as result of		
					finding. The physician is aware	e of	
	Review of physic	cian's orders indicated			this resident's blood sugar results.		
	Resident #18 was	s to receive sliding scale			How will you identify other		
		rerage AC (before meals)			residents having the potentia	ıl İ	
	as well as insulin	coverage at HS			to be affected the same		
	(bedtime). The p	_			deficient practice and what		
	indicated:	,			corrective action will be take	n?	
	"1/17/11 Humalo	og Insulin coverage: AC			All residents with orders for Sliding Scale Insulin have the		
	(before meals):				potential to be affected by this		
	110-125=1u (uni	t)			finding and will be identified		
	126-140=2u	,			through a facility audit. This au		
	141-160=3u				will ensure that all residents wi orders for sliding scale insulin		
	161-180=4u				receiving the appropriate dosa		
	181-200=5u				Any noted discrepancies will b	- 1	
	201-240=6u				clarified and corrected at the ti		
	241-280=7u				noted. The Nurse Managemen	it	
	281-320=8u				Team is responsible for the completion of this audit.		
	321-360=9u				What measures will be put in	to	
		60=10u & call MD			place or what systemic		
	- (greater than) 30	oo-rou & can mid			changes you will make to		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING		COMPLETED
		155695	A. BUII			02/11/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER					
DI) (EDO)	551/11/14/05				/ FRANKLIN ST	
RIVERSI	DE VILLAGE			ELKHA	RT, IN46516	
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES			ID	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	(Medical Doctor)	Ì		ensure that the deficient	
	,	,			practice does not recur?	
	II	and the street			A nursing in-service will be he	ld
	_	coverage: HS (bedtime)			on 03/10/2011. This in-service	will
	140-160=1u				include review of the facility po	- 1
	161-180=2u				titled, "Blood Glucose Monitori	- 1
	181-200=3u				This in-service will also include	=
	201-220=4u				review of transcription and	
	221-240=5u				documentation practices relate	
	241-280=6u				to blood glucose monitoring. T policy titled,"Medication Error"	
					will be reviewed at this nursing	I
281-320=7u				in-service as well.	'	
321-360=8u				How will the corrective		
361-400=9u >400=10u & call MD				action(s) be monitored to		
					ensure the deficient practice	
	A physician's ord	der, dated 01/27/11,			will not recur, i.e. what qualit	
		discontinue) Humalog;			assurance program will be p	-
	,	,			into place?	
	start Novulog ins	Suilli for SSI.			To ensure ongoing compliance	e
					with this correction action, the	
	Review of "Capi	llary Blood Glucose			DNS and/or designee will be	
	Monitoring Tool	" for 01/24/11 through			responsible for completing the	
	02/10/11, indicat	ed the following wrong			CQI audit tool titled, "Blood	
	Insulin doses giv				Glucose Machines and	۵:4
	_	ucose Reading / Units of			Testing/Accu-checks". This au tool will be completed weekly	I
					weeks and monthly thereafter.	
	Insulindosage of	oruereu			Data will be submitted to the C	I
					Committee for review and follo	
	01/24/11: 159 /	3u1u			up. In addition, the CQI audit t	· · ·
	01/25/11: 207 /	6u4u			titled, "Medication Errors" will I	
	01/26/11: 192 /	5u3u			completed monthly x3 months	
	01/27/11: 238 /				then quarterly thereafter.	
	01/28/11: 258/				Compliance Date: 03/13/2011	
	01/29/11: 251 /					
	01/30/11: 226 /					
	01/31/11: 222 /	6u5u				
	02/01/11: 142 /	3u1u				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			A. BUILDING	E CONSTRUCTION	(X3) DATE COMP 02/11/2	LETED
	PROVIDER OR SUPPLIER		1400	ET ADDRESS, CITY, STATE, ZIP CODE O W FRANKLIN ST HART, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	marked as given- 02/10/11: 237/ Interview with L	4u2u 8u7u 6u crossed out & 5u 3u				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155695	B. WIN		02/11/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				/ FRANKLIN ST	
RIVERSI	DE VILLAGE				RT, IN46516	
			_			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
F0334		review and interview, the	F03	34	F 0334 What corrective	03/13/2011
SS=D	facility failed to	ensure the administration			action(s) will be accomplished	ea
	of annual influen	za vaccine as ordered			for those residents found to have been affected by the	
	and consented fo	r 2 of 18 residents			deficient practice? It is the	
	reviewed in a sar	nple of 18 for yearly			practice of this provider to ens	ure
	influenza vaccine				the administration of annual	
	mmacmza vacemo	(1105, 1100)			influenza vaccine as ordered a	and
	Eindines in de de	_			consented for each resident.	
	Findings include				Resident # 50 received the flu	
					vaccine on 02/07/2011. Reside	
		ecord of Resident # 50			# 89 has been discharged from	
	was reviewed on	2/7/11 at 2:00 p.m., and			the facility. None of the identifi residents experienced any	eu
indicated the resident had diagnoses				negative outcome as a result of	of	
	which included, 1	but were not limited to,			this finding. How will you	
	hypertension and	Alzheimer's disease.			identify other residents having	ng
	31				the potential to be affected th	ne
	The physician's c	order sheet dated 11/3/09,			same deficient practice and	
		er to administer the			what corrective action will be	•
					taken? All residents have the	
	influenza vaccii	nation.			potential to be affected by this	
					finding. A facility audit will be	
		g the end of the day			conducted by the Nurse Management Team. This audi	<u>,</u>
	meeting with the	facility staff, information			will review all resident	`
	was requested in	regard to if the resident			immunization records to ensur	re l
	had received the	influenza vaccine.			consents are present and	
					vaccines are given and record	I
	On 2/9/11 at 8·14	a.m., the Director of			on the immunization record. A	ny
		(DNS) was queried in			noted discrepancies will be clarified and corrected	
	_	esident had received her			immediately. What measures	
	_	e. The DNS indicated on			will be put into place or what	
					systemic changes you will	,
		y had done an audit on			make to ensure that the	
		edical record and found			deficient practice does not	
	the resident had i	not received her influenza			recur? A nursing in-service wi	
	vaccine.				be conducted on 03/10/2011.	
					This in-service will include revi	iew
					of the facility policy titled	
					!	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) es dated 2/7/11 at 1655	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY) "Influenza and Pneumococca	DATE		
	(4:55 p.m.) indice the Power of Att unavailable, in rewanted the residuaccine. On 2/7, the POA returned indicated the residuaction and the received the vaccine approval to admit vaccine. 2. The closed classification was reviewed a.m., and indicated diagnoses which limited to, hyper disease. On the Influenza dated 9/16/10, in responsible party administer the in On 2/11/11 at 9:1 the Infection Coulomb and documented resident had receivaccine; the book resident's record. Immunization Receivaccine and the resident record.	ated a call was placed to orney (POA), who was egard to if the POA ent to have the influenza (11 at 2045 (8:45 p.m.)) d the phone call and ident had not already cine and gave verbal enister the influenza (inical record of Resident ed on 2/10/11 at 10:15 ed the resident had included, but were not tension and Alzheimer's (inicated the residents of had given permission to fluenza vaccine.		Influenza and Pneumococca Immunization" How will the corrective action(s) be monitored to ensure the deficient practice will not rei.e. what quality assurance program will be put into place. The DNS or designee will complete the CQI audit tool tir "Infection Control" monthly x3 then quarterly thereafter to ensure ongoing compliance. Findings will be submitted to the CQI Committee for review and follow up. Compliance date: 03/13/2011	cur, ce? dled,		

NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE (X4) ID SUMMARY STATEMENT OF DEPICIENCIES (FACH DEPICIENCY MUST BE PERCEDED BY PELL. TAG 3.1-13(a) 3.1-13(a) SIRLET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516 PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION OF COMPLETION DATE (X7) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION DATE (X5) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COMPLETION OF COMPLETION DATE (X7) PROVIDERS PLAN OF CORRECTION OF COMPLETION OF COM	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE S COMPL 02/11/20	ETED
RIVERSIDE VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			100000	B. WING	ADDRESS CITY STATE ZIB CODE	02/11/2	
RIVERSIDE VILLAGE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ELKHART, IN46516 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) DATE OATE	NAME OF P	ROVIDER OR SUPPLIER		l l			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY COMPLETION DATE				ELKHA			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE					PROVIDER'S PLAN OF CORRECTION	R	
					CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	
			LSC IDENTIFYING INFORMATION)		GROSS-REPERENCE I I I HE APPROPR DEPICIENCY)	WATE	
lacksquare							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIZ	DING		COMPL	ETED
		155695	A. BUII			02/11/20	011
			B. WIN		ADDRESS CITY STATE TIL CODE		
NAME OF F	PROVIDER OR SUPPLIER	S.			ADDRESS, CITY, STATE, ZIP CODE		
DIVEDOI				1	FRANKLIN ST		
KIVEKSI	DE VILLAGE			LLKHA	RT, IN46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0387	Based on record	review and interviews,	F03	87	F 0387	.	03/13/2011
SS=D	the facility failed	l to ensure physician			What corrective action(s) wil	·	
	visits were every	30 days for the first 90			be accomplished for those	_	
	_	ter every 60 days, for 1 of			residents found to have been	י ן	
	_	ewed for physician visits			affected by the deficient practice?		
		Resident #17)			It is the practice of this provide	ar	
	in a sample of re	5. (Resident #17)			that the medical care of each	-	
					resident is supervised by a		
	Findings include	:			physician and that each physic	cian	
	The record of Resident #17 was reviewed on 02/07/11 at 1:00 p.m. Resident #17 was admitted to the facility on 05/20/10				visit occurs timely per regulation	on.	
					Residenti# 17's physician has been		
					updatied regarding her currenti		
					stiatiusResidenti# 17 did noti		
		ncluding, but not limited			experience any negative outicome a	is	
	_	ary Artery Disease),			a resulti of tihis fnding		
	,	Congestive Heart Failure),			How will you identify other		
		,,			residents having the potentian to be affected the same	aı	
	-	epression. Review of			deficient practice and what		
		PROGRESS NOTES",			corrective action will be take	n?	
	since admission	05/2010, indicated the			All residents have the potentia		
	resident was seen	n on the following dates:			be affected by this finding. A		
	06/02/10				facility audit of all records will	be	
	07/14/10				completed by the Nurse		
	11/29/10				Management Team. This audi		
	01/11/10				will ensure physician visits are		
	V1/11/10				timely and comply with state a		
	Turkamaia 341 41	on Committee DN Comple			federal regulations. Physicians will be notified promptly with a		
		ne Consultant RN for the			identified concerns.	,	
		02/10/11 at 9:00 a.m.,			What measures will be put in	ito	
		vas no further information			place or what systemic		
	in regard to a phy	ysician's visit.			changes you will make to		
					ensure that the deficient		
	3.1-22(d)(1)				practice does not recur?		
					A nursing in-service will be		
					conducted on 03/10/2011. Thi		
					in-service will review the facilit policy titled, "Physician Visit	y	
					policy lillou, i riyalciari viall		
			1		İ		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WWYP11 Facility ID:

003075

If continuation sheet

Page 50 of 65

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			A. BUILDING B. WING	UNSTRUCTION	COMPLETED 02/11/2011	
	ROVIDER OR SUPPLIER		STREET 1400 W	ADDRESS, CITY, STATE, ZIP CODE V FRANKLIN ST ART, IN46516	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
				Requirements Protocol". The nursing staff will be re-educat regarding required physician for new admissions and routin visits. Medical Records and/o other designee will be responsor for maintaining physician visit schedule. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what qualit assurance program will be printo place? Medical Records and/or design will be responsible for complete of the CQI audit tool titled, "Physician Services". The auditool will be completed weekly weeks and then monthly thereafter to ensure ongoing compliance. Data will be submitted to the CQI Committo review and follow up. Compliance Date: 03/13/201	visits ne or risible d e ity out gnee etion dit x4	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155695	B. WIN			02/11/2011	
RIVERSI	PROVIDER OR SUPPLIER			STREET A 1400 W ELKHA	ADDRESS, CITY, STATE, ZIP CODE V FRANKLIN ST ART, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0441	interviews, the far policy for manton (Resident #33), a control procedure feeding and dress #80, #65), and not hamper (Residen practice affected reviewed for infersample of 18, and supplemental sample and the shower room potentially affect reside on the Heri Findings included 1. The clinical rewas reviewed on and indicated an 12/20/10. Documentation should be in the feed of the treatment of the feed read nor that the treatment of the feed read nor that the feed on within the 1 feed of the feed on within the 1 feed on the feed on within the 1 feed on the feed on th	ection control in the d 1 of 2 residents in the mple. The facility also a sanitize shower chairs in on 1 of 3 units, ing the 37 residents who entage unit. Eccord of Resident #33 2/9/11 at 10:10 A,M, admission date of a mentation on the eet indicated a mantoux est had been administered ere was no of indicate the result had at a second step mantoux and been done or that a lin skin test had been	F04	41	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provide maintain an Infection Control program that is designed to provide a safe, sanitary, comfortable environment and prevent the development of an transmission of disease and infection. Resident # 33 has been discharged from the facility. Resident # 80 continues with bolus feeding and did not experience any negative outco as a result of this finding. Resident # 74 continues with treatment for contact dermatitic and linen hamper is emptied every shift by nursing staff. The resident experienced no negative outcome as a result of this finding. Resident # 65 continues with treatment to lower extremities. This resident experienced no negative outcome as a result of this finding. All shower chairs have been properly disinfected per facility policy. Any identified staff members we be thoroughly in-serviced/re-educated on protechnique in regards to Manton documentation, administration	er to and brian brian come s is tive of oper ux	03/13/2011

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION		A. BUI	LDING		02/11/2011	
		155695	B. WIN			02/11/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	V FRANKLIN ST		
RIVERSI	DE VILLAGE			LELKHA	ART, IN46516		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	l *	2/10/11 at 9:00 a.m.,			enteral feedings, disinfecting of		
	indicated there w	as no further information			resident care equipment/suppl hand washing, glove use and	iles,	
	in regard to the d	ocumentation of the			handling of linen.		
	mantoux tuberculin test.				How will you identify other		
					residents having the potentia	al	
	2. On 2/8/11 at 10:50 A.M., nurse #20 was observed to remove the piston (the				to be affected the same		
					deficient practice and what		
		ringe) from the syringe			corrective action will be take	n?	
	^	• •			All residents are at risk to be		
	1 ^	ering a bolus G (gastric)			affected by this finding.		
	~	lesident #80. She placed			What measures will be put in place or what systemic	ito	
		blanket which was on			changes you will make to		
	top of the resider	nt's bed. When the bolus			ensure that the deficient		
	feeding was finis	hed, nurse #20 placed the			practice does not recur?		
	piston back insid	e the syringe and placed			An all nursing staff in-service	will	
	both in a plastic	container, ready for the			be conducted on 3/10/2011. T		
	next bolus feedin	ıg.			in-service will include review of		
					facility Infection Control practio		
	 During interview	y, on 2/11/11 at 1:50			including a specific emphasis Tuberculin Skin Testing		
	~	idicated the syringe			administration and		
		ve been placed on a towel			documentation.		
	_	-			Administration of entera	ıl	
	and not on the bl	anket.			feedings using proper infection	n	
					control technique.		
		2:00 P.M., on the			Facility protocol regarding disinfectant of shower chairs.	ng	
		NA #22 was queried in			Facility protocol regarding	na	
	1	cedure to sanitize the			safe handling and disposal of	'8	
	shower chairs. T	The CNA indicated she			soiled linen in hampers.		
	would spray the	shower chair and leave			Proper hand washing and glov		
		5 minutes. She was			practices during routine reside	ent	
		ne of the solution.			care and dressing changes.		
					How will the corrective		
	Two procedures	for sanitizing shower			action(s) be monitored to		
	_				ensure the deficient practice will not recur, i.e. what qualit	I	
	1 ^	ed on the wall in the			assurance program will be p	- 1	
	Heritage unit soil	led utility room. One of			into place?		
					<u> </u>		

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155695	- 1	LDING		02/11/20		
		133033	B. WIN		A DEPENDE OF THE CORE	02/11/20	711	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
RIVERSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516					
		FATEMENT OF DEPLOIPMONE					(7/5)	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
	the procedures, u	indated, was to spray the			The Charge Nurses and Nurse)		
	•	h TB quat and leave for			Management Team will monito	or		
		e second procedure,			for proper infection control			
		spray the solution and			practices and procedures by making routine and random			
		nutes. The solution was			walking rounds observing for			
	not named.				compliance. In addition, all nui	rses		
					will be required to do a			
	On 2/9/11 at 8:40	A.M., the infection			check-off/return demonstration administration of enteral feeding			
	control nurse ind				as well as a dressing change t			
		was to leave the solution			ensure ongoing compliance wi	ith		
		and the solution being			this corrective action. Any observed concerns noted during	200		
	used was TB qua	•			check-offs will be addressed a	·		
	•				corrected immediately.			
	4. The clinical re	ecord of Resident #74			DNS and/or designee is			
	was reviewed on	2/9/11 at 1:40 P.M., and			responsible for completion of t CQI audit tool titled, "Resident			
		dent was being treated			Care Rounds" will be complete			
	for contact derma	atitis and that all her bed			weekly x4 weeks, then monthl			
	linens, towels, w	ashcloths and			x3 months, and then quarterly			
	incontinence pad	s were washed separately			thereafter to ensure ongoing compliance. The CQI audit too	, I		
	with a different d	letergent.			titled, "Infection Control Review			
					will be completed weekly x4			
	On 2/8/11 at 3:40	P.M., during			weeks then monthly thereafter			
	incontinence care	e for resident #74, the			ensure ongoing compliance. During this audit will be submitte			
	linen hamper, ad	jacent to the bed,			the CQI committee for review			
	specifically for re	esident #74, was			follow up.			
	observed to be fu	all to overflowing. At			Compliance Date: 03/13/2011			
	this time, CNA #	21 said she thought						
	housekeeping sta	iff was supposed to						
	empty the linen h	namper; however, the						
		he CNAs were supposed						
	to empty the line	n hamper and remove the						
	soiled linen.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			A. BUILDING CO			(X3) DATE COMPL 02/11/2	ETED
	PROVIDER OR SUPPLIER DE VILLAGE SUMMARY S'	FATEMENT OF DEFICIENCIES	p. wind	STREET A	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION DATE
F0441	was reviewed on Resident #65 was on 02/19/10 with not limited to, and chronic CHF (Codiabetes, peripher (Peripheral Vasci circulation/blood the record for Resident had stass by poor circulation extremities and his changes. On 02/09/11, bet 11:10 a.m., LPN change the right dressings. LPN in DNS (Director Non DNS was observed to put on clean glove the right and the dressings. The Engloves and washing putting on clean observed to move bedding to the overall dressing supplies table, and move that from one area of DNS than lifted and the original properties.	ecord for Resident #65 02/08/11 at 1:30 p.m. s admitted to the facility diagnoses including, but retic stenosis, anemia, ongestive Heart Failure), ral neuropathy, and PVD ular Disease: poor perfusion). Review of sident #65 indicated the is ulcers (ulcers caused on) to both lower had daily dressing ween 10:10 a.m. and #3 was observed to and left lower extremity #3 was assisted by the fursing Services). The ed to wash her hands and res before removing both left lower extremity ONS then removed her ed her hands before gloves. The DNS was e a notebook from the ver-bed table, rearrange s on top of the over-bed the resident's slippers the bed to another. The and placed Resident #65's e exposed open area	F04-	41	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provide maintain an Infection Control program that is designed to provide a safe, sanitary, comfortable environment and prevent the development of an transmission of disease and infection. Resident # 33 has been discharged from the facility. Resident # 80 continues with bolus feeding and did not experience any negative outco as a result of this finding. Resident # 74 continues with treatment for contact dermatitis and linen hamper is emptied every shift by nursing staff. The resident experienced no negative outcome as a result of this finding. Resident # 65 continues with treatment to lower extremities. This resident experienced no negative outcome as a result of this finding. All shower chairs have been properly disinfected per facility policy. Any identified staff members we be thoroughly in-serviced/re-educated on protechnique in regards to Manton documentation, administration	er to and brian brian come s is tive of pper ux	03/13/2011

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUR COMPLETE	
		155695				02/11/2011	
			B. WIN		ADDRESS OF A STATE SID CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DI\/EDQI	DE VILLAGE			1	V FRANKLIN ST		
					ELKHART, IN46516		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CC	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	located on the po	sterior (back) of the leg,			enteral feedings, disinfecting		
	directly onto the	bedding. The DNS			resident care equipment/supp hand washing, glove use and	iles,	
	removed the glov	ve from the right hand,			handling of linen.		
	opened the room	door and exited with the			How will you identify other		
	left glove on. Th	e DNS then returned to			residents having the potenti	al	
		ed the left glove and			to be affected the same		
	l '	ean gloves. The DNS			deficient practice and what		
	"	e anterior (front) left			corrective action will be take	en?	
		` '			All residents are at risk to be		
	_	ith NS (normal saline)			affected by this finding.		
	_	ea dry with a clean towel.			What measures will be put in place or what systemic	110	
	The DNS proceeded to cleanse an area on				changes you will make to		
	the upper right ankle with NS and patted				ensure that the deficient		
	it dry with a clear	n towel. The DNS			practice does not recur?		
	removed her glov	ves and regloved to			An all nursing staff in-service	will	
	measure the affect	cted areas. The DNS			be conducted on 3/10/2011. T	his	
	again removed he	er gloves and put a glove			in-service will include review of	I .	
	-	to measure the depth an			facility Infection Control practi		
	I -	Q-tip, removed the right			including a specific emphasis Tuberculin Skin Testing		
	1 ^	ed. The DNS then picked			administration and	' l	
	-	ve from the floor and			documentation.		
					Administration of entera	al	
	_	h can with her gloved			feedings using proper infectio	n	
		again removed her			control technique.		
	~ ~	ved to assist LPN #3 by			Facility protocol regardi disinfectant of shower chairs.	ng	
	holding the lower	r extremities of Resident			Facility protocol regardi	ng	
	#65.				safe handling and disposal of	·	
					soiled linen in hampers.		
	Interview with th	e ADNS (Assistant			Proper hand washing and glo		
	Director Nursing	Services), on 02/09/11			practices during routine reside	ent	
	·	gard to infection control,			care and dressing changes.		
	l	ould wash hands before			How will the corrective		
		ving for resident care			action(s) be monitored to ensure the deficient practice	,	
		•			will not recur, i.e. what quali		
	1 ^	Handwashing Policy,			assurance program will be p	- 1	
	provided by the A	ADNS at the time, did not			into place?		
					1 .		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155695	A. BUILDING		02/11/2011
		10000	B. WING	ADDRESS SITE OF THE CORE	02/11/2011
NAME OF F	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST	
RIVERSI	DE VILLAGE		1	RT, IN46516	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	specify when directo wash their ham 3.1-18(f) 3.1-18(l)	ect care personnel were ads.		The Charge Nurses and Nurse Management Team will monite for proper infection control practices and procedures by making routine and random walking rounds observing for compliance. In addition, all nu will be required to do a check-off/return demonstration administration of enteral feedi as well as a dressing change ensure ongoing compliance withis corrective action. Any observed concerns noted duricheck-offs will be addressed a corrected immediately. DNS and/or designee is responsible for completion of CQI audit tool titled, "Resident Care Rounds" will be complete weekly x4 weeks, then monthly x3 months, and then quarterly thereafter to ensure ongoing compliance. The CQI audit tool control and tool to the complete compliance. The CQI audit tool compliance.	rses n on ngs to ith ng and the ted
				compliance. The CQI audit too titled, "Infection Control Revie will be completed weekly x4 weeks then monthly thereafter ensure ongoing compliance. If from this audit will be submitted the CQI committee for review follow up. Compliance Date: 03/13/2011	w", r to Data ed to and

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155695	A. BUII B. WIN			02/11/2011	
RIVERSI (X4) ID		FATEMENT OF DEFICIENCIES		STREET A 1400 W ELKHA	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST RT, IN46516 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0502 SS=D	facility failed to deperformed blood physician in regal (prothrombin time). This deficiency is reviewed for labor of 18. (Resident is Findings include). The clinical recovereviewed on 2/7/indicated diagnoss were not limited (congestive heart fibrillation. There was a physical structure of the properties of the prope	ne/international ratio). affected 1 of 4 residents bratory tests in a sample #42)	F05	02	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provide provide or obtain laboratory services to meet the needs of residents and that the facility is responsible for the quality and timeliness of these services. How will you identify other residents having the potentiat to be affected the same deficient practice and what corrective action will be taken Resident # 42's lab orders have been obtained as ordered. The Physician is aware of this resident's current status. The identified resident experienced negative outcome as a result of this finding. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? All residents with orders for PT/INR's have the potential to affected by this finding. A facilia audit will be completed by the Nurse Management Team. The audit will review all residents with physician's orders for PT/INR's ensure all labs have been obtained as ordered. Any identified discrepancies will be corrected and/or clarified wher noted.	er to its its its its its its its its its its	03/13/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/11/2011
	ROVIDER OR SUPPLIER		1400 W	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST .RT, IN46516	
	DE VILLAGE SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1400 W	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) A nursing staff in-service will conducted on 3/10/2011. Thi in-service will include review the facility policy titled, "Guidelines for Lab Tracking The in-service will emphasis importance of following phys orders regarding lab monitor and timely notification and fou with all lab results. How will the corrective action(s) be monitored to ensure the deficient practic will not recur, i.e. what qua assurance program will be into place? Ongoing compliance with thi corrective action will be mon through the facility CQI prog. The DNS or designee will be responsible for completion o CQI audit tool titled, "Couma Therapy" weekly x4 weeks, to	be so of ". the ician ing allow be lity put so itored ram. If the din hen
				monthly x3 months, and ther quarterly thereafter. In additi the facility will utilize the Coumadin Flow Record to monitor residents on Couma Therapy. Data will be submit to the CQI Committee for revand follow up. Compliance Date: 03/13/201	on din ted view

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETI	ED
		155695	B. WIN			02/11/201	1
			В. WIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				/ FRANKLIN ST		
RIVERSI	DE VILLAGE			l	RT, IN46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0507	Based on review	of records and interview,	F05	07	F 0507		03/13/2011
SS=D	the facility failed	to ensure laboratory			What corrective action(s) wil	l l	
	reports were filed	d in the clinical record.			be accomplished for those		
	This deficiency affected 3 of 4 residents reviewed for laboratory results, in a sample of 18. (Residents #67, 42 and 74)				residents found to have beer	1	
					affected by the deficient practice?		
					It is the practice of this provide	r to	
					ensure that laboratory results		
					accessible and placed in the		
	Findings include	:			clinical record.		
	1. The clinical record of Resident #67 was reviewed on 2/10/11 at 10:25 A.M., and indicated diagnoses which included				Resident # 67, Resident # 42,		
					and Resident # 74's clinical		
					records have been reviewed a	nd	
					all ordered lab reports are accessible and filed in each		
		ted to CVA (cerebral			resident's clinical record.		
		t- stroke) and diabetes			How will you identify other		
	mellitus.	stroke) and diabetes			residents having the potentia	ı İ	
	memus.				to be affected the same		
	m.				deficient practice and what		
		ler for a lipid panel to be			corrective action will be take	n?	
	done yearly. Th				All residents with orders for lat		
	documentation in	the clinical record to			work are at risk to be affected		
	indicate this had	been done. On 2/10/11			this finding and will be identified		
	at 3:15 P.M., the	DNS indicated the lipid			through a facility audit. This au will review all residents with	idit	
		one on 11/9/10, however,			physician orders for lab draws	to	
	-	t been received in the			ensure all labs have been	.	
	facility.	t dean received in the			obtained as ordered and are		
	iaciiity.				accessible and filed in each		
) The alimin 1	manand of D: dt #40			resident's clinical record. Any		
		record of Resident #42			identified discrepancies will be		
		2/7/11 at 2:10 P.M., and			corrected/ clarified when noted		
		ses which included but			What measures will be put in place or what systemic	ιυ	
	were not limited	to dementia, Atrial			changes you will make to		
	fibrillation and C	HF (congestive heart			ensure that the deficient		
	failure).				practice does not recur?		
	•				An all nursing staff in-service v	vill	
	There was a phys	sician's order for a Kepra			be conducted on 03/10/2011 to		
		order for a repra			review the facility process for		
					<u> </u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
155695		B. WING		02/11/2011			
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516 ID (X5)				
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
	There was no rest the clinical record A.M., the DNS preport of the kept report was marked on 2/10/11 at 18: 3. The clinical record was reviewed on indicated diagnost were not limited. A physician's order a pre-albuminate next laborato indicated the test 11/10/10, however received in the factors.	record of Resident #74 2/9/11 at 1:40 P.M., and ses which included but to dementia. der, dated 11/8/10, was a lab test to be done on ry day. Documentation that been done on er the results were not accility until 2/9/11. A received in the facility on		obtaining, reporting, and filing reports. The Nurse Managers and/ or other designees will ensure all labs are filed in the clinical record after nursing ha reported results to the physicial How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what qualit assurance program will be pinto place? The DNS or designee will be responsible for completion of the CQI audit tool titled, "Labs/Diagnostics" weekly x4, then monthly x3, and then quarterly thereafter for ongoing compliance. Any identified trem will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	s an. y ut he		

STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COM		ETED
155695		B. WING			02/11/2011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				l	/ FRANKLIN ST		
RIVERSIDE VILLAGE				l	RT, IN46516		
RIVERSIDE VILLAGE							
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0514	Based on interview	ews and record reviews,	F 0514 F 0514 What corrective action(s) will			03/13/2011	
SS=D	the facility failed	to assure documentation				.	
	of physician noti	fication was complete in			1	'	
	regard to a positive tuberculin test result for 1 resident. This deficiency affected 1 of 1 resident in a sample of 18 who had a positive		residents found to ha affected by the deficie practice?		be accomplished for those residents found to have been affected by the deficient		
					-		
					It is the practice of this provide	er to I	
	•	-			ensure clinical records are complete and accurately		
	tubercuiin test re	sult (Resident # 45).					
	Findings Include: The clinical record of Resident # 45 was				documented.		
					How will you identify other	.	
					residents having the potentia	1	
					to be affected the same deficient practice and what		
	reviewed on 2/8/11 at 1:30 p.m., and				corrective action will be take	_{n2}	
	indicated the resident had diagnoses				Resident # 45's clinical record		
	included but not limited to, depression				has been updated to reflect a		
	and Alzheimer's disease.				positive tuberculin test and		
					physician and family notification	n.	
					What measures will be put in	to	
		on Record was dated			place or what systemic		
	11/19/10, the Mantoux test was read on 11/21/10, and indicated a positive test result of seventeen millimeters. The Radiology result for a chest radiological result dated 11/16/10, indicated there was no evidence of cardiopulmonary disease.				changes you will make to		
					ensure that the deficient		
					practice does not recur?		
					All residents are at risk to be affected by this finding. All		
					resident charts will be audited	to	
					ensure tuberculin test results		
					have been properly recorded i	n	
					the clinical record as well as the		
					presence of the physician and		
	Cardiopullionary	uiscase.			family notification.	.,,,	
	Nurses Notes dated 11/21/10, indicated there was no documentation the physician was notified of the positive Tuberculin				An all nursing staff in-service was be conducted on 03/10/2011.	viii	
					This in-service will include revi	_{iew}	
					of the facility process for		
					obtaining, reporting, recording	,	
	test result.				and filing tuberculin test result	s in	
					the clinical record. The nurse	.	
					mangers or other designee wil	I	
					!		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/11/2011			
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR On 2/9/11 at 8:1. Nursing Services to no documenta was notified on 1 positive Tubercu The DNS indicat physician was no Tuberculin test of orders were rece Practitioner was informed of the to On 2/9/11 at 8:4. Control Nurse w documentation the notified on 11/21 Tuberculin test. The Infection Co previous Assista Services(ADNS) 11/21/10, in the set	ted the resident's of tified of the positive on 11/21/10, and no new lived and the Nurse at the facility and was rest result. O a.m., the Infection as queried in regard to no nat the physician was 1/10, of a positive ontrol Nurse indicated the nt Director Nursing had not documented on resident's medical record fied the physician, the and the Department of to the positive	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) ensure all tuberculin result filed in the clinical record a physician and family notific How will the corrective action(s) be monitored to ensure the deficient pract will not recur, i.e. what quassurance program will be into place? The DNS or designee will be responsible for completion CQI audit tool titled, "Resid Mantoux" monthly x3 mont then bi-annually thereafter ensure ongoing compliance findings will be submitted to CQI Committee for review follow up. Compliance Date: 03/13/20	s are fter ation. ice fality e put oe of the lent hs and to e. Any or the and	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLI	COMPLETED	
155695		155695	B. WING			02/11/2011		
			B. WING		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					/ FRANKLIN ST			
RIVERSIDE VILLAGE					RT, IN46516			
KIVEKSI	DE VILLAGE			LLKIIA				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE	
F0516	Based on observa	ation and interview, the	F05	F0516			03/13/2011	
	facility failed to	safeguard clinical record	be accom residents affected b					
	information again	nst unauthorized use in			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?			
	regard to availab	ility of the keys. This						
	_	ed 2 of 2 clinical record						
	storage rooms.							
	storage rooms.				It is the practice of this provide	r I		
	Pin 4in in .1 4.				that all clinical record information			
	Findings include				is safeguarded against loss,			
					destruction, or unauthorized us	se.		
		nvironment tour on			How will you identify other	.		
	2/8/11 at 1:25 P.1	M., accompanied by the			residents having the potentia	1		
	maintenance and housekeeping supervisors, the following was observed: The record room door was locked and there was no-one in the room. There were 12 clinical record metal file cabinets in				to be affected the same deficient practice and what			
					corrective action will be take	_{n2}		
					The identified storage room lo			
					have been replaced and new			
					keys have been distributed on	ly to		
					appropriate personnel.			
					No other clinical record storage			
		rd/medical record office,			rooms were noted to be affect	ed		
	and three of the c	cabinets were unlocked.			by this finding.	.		
					What measures will be put in place or what systemic	10		
	When queried, at	t this time, the			changes you will make to			
	maintenance sup	ervisor and the			ensure that the deficient			
	housekeeping su	pervisor both indicated			practice does not recur?			
	they had a key fo	or this room.			An all staff in-service will be			
					conducted on 03/10/2011. This			
	The second medi	ical record storage room			in-service will include review o	f		
	The second medical record storage room was locked and records were in plastic bins with lids. The medical records staff person indicated human resources staff and the business office staff had keys for				the facility practice regarding	, ha		
					storage of clinical records and regulation regarding authorize			
					access to these clinical record			
					How will the corrective	··		
					action(s) be monitored to			
		e of the plastic bins			ensure the deficient practice			
	contained employee and business records.				will not recur, i.e. what quality			
					assurance program will be p	ut		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
155695		B. WING		02/11/2011			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
RIVERSI	DE VILLAGE		1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID		FATEMENT OF DEFICIENCIES	ID ID	1	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	3.1-50(d)			into place? Ongoing compliance with this corrective action will be monitor through completion of the CQI audit tool titled, "Facility, Environmental Review" weekly then monthly thereafter. The Maintenance Director, Medica Records, and/or other designed will be responsible for complete Compliance Date: 03/13/2011	ored / x4 I se		